CARPENTERS HEALTH AND WELFARE TRUST FUND FOR CALIFORNIA

HEALTH & WELFARE PLAN FOR RETIREES SUMMARY PLAN DESCRIPTION

Nota: Este folleto contiene un resumen en ingles de los derechos y beneficios que existen en su Plan de Retiro para Carpenters Health and Welfare Trust Fund for California. Si tiene dificultad en leer o entender la información, por favor comuniquese con el departmento de beneficios en la oficina de fondos al siguiente domicilio: 265 Hegenberger Road, Suite 100, Oakland, California, 94621-1480. La oficina esta abierta de lunes a viernes, de 8:00 a.m. – 5:00 p.m. Si prefiere, nos puede llamar al numero (510) 633-0333 o linea telefonica gratuita (888) 547-2054.

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Enroll in Medicare

It is very important that you enroll in **both Part A and Part B** of Medicare when you turn 65, or if you become disabled and eligible for Social Security benefits before age 65. Failure to enroll in **both** parts of Medicare could create serious financial hardship for you.

Indemnity Plan: On the first day of the month you become eligible for Medicare, the medical Plan will assume that Medicare has covered the charges, regardless of whether you have actually enrolled for Medicare and regardless of whether Medicare makes any payment. This means that the Plan will pay **only 20%** for services normally covered by Part B of Medicare and only the Medicare inpatient hospital deductible amount if you are hospitalized and you will be responsible for any remaining charges.

Kaiser HMO: Members eligible for Medicare must also enroll in Parts A and B of Medicare and assign their Medicare benefits to Kaiser. If you are enrolled in Kaiser and you do not enroll in both Parts A and B of Medicare when eligible and assign Medicare to Kaiser, your coverage in Kaiser will be terminated. In this case, you may be allowed to enroll in the Indemnity Plan; however, if allowed, the Indemnity Plan will pay as though you had enrolled in both parts of Medicare as described above.

See page 18 for information on how to enroll in Medicare.

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Introduction

This Summary Plan Description (SPD)/Rules and Regulations is designed to help you understand the benefits available to you through the Carpenters Health and Welfare Trust Fund for California.

The Plan described in this SPD is effective March 1, 2024 and replaces all other Plan documents previously provided to you.

About This SPD

In this Summary Plan Document we have tried to describe your benefits as completely as possible and in everyday language.

The document is divided into four sections:

Section 1 – Retiree Health and Welfare Plan Overview. This section provides general information applicable to all benefits and Participants.

Section 2 – Indemnity Plan for Retirees without Medicare. This section provides specific information about benefits for Participants enrolled in the Indemnity Plan who are not yet eligible for Medicare.

Section 3 – Indemnity Plan for Retirees with Medicare. This section provides specific information about benefits for Participants enrolled in the Indemnity Plan who are also eligible for Medicare.

Section 4 – Plan Rules – Exclusions & Limitations, Claims, Appeals and Administration. This section provides detailed information pertaining to the Indemnity Medical Plan, both Pre-Medicare and with Medicare.

Section 1 - Retiree Health and Welfare Plan Overview

This Section includes:

- A brief description of the **Plan benefits, choices and coverage** available to qualified Participants.
- An explanation of some important commonly used **terms and phrases with special meanings**.
- An **administrative information** section including additional Plan information and your rights under the law.
- An important **contact information** section, which includes telephone numbers and websites for the Fund Office and other organizations providing services under the Plan.
- An **eligibility** section that summarizes the eligibility requirements that you must satisfy to qualify for benefits.
- A section about rules pertaining to **Continuation Coverage under COBRA**

Este documento contiene una breve descripción sobre sus derechos de beneficios del Plan, en Ingles. Si usted tiene dificultad en comprender cualquier parte de este documento, por favor de ponerse en contactó con la Fund Office a la dirección y teléfono en el Quick Reference Chart de este documento.

Plan Benefits, Choices and Coverage

The Retiree Health and Welfare Plan offers a wide range of benefits that are described in this SPD, including:

- Indemnity Medical Plan;
- Kaiser HMO plan (This SPD has a limited description of benefits; please refer to the Evidence of Coverage (EOC) for a full description of benefits. The EOC can be found on the Trust Fund website, www.carpenterfunds.com.);
- Mental Health and Chemical Dependency benefits;
- Prescription Drug benefits;
- Hearing Aid benefits for Indemnity Medical Plan; and
- Vision Care benefits for Indemnity Medical Plan Participants.

This booklet does not contain a complete description of the Kaiser plan or information on the voluntary Retiree dental program through Delta Dental. These plans are described in separate brochures.

Note: Dental benefits are also available through a voluntary Retiree dental program insured by Delta Dental. The dental plan requires a separate enrollment, payment of premiums covering the full cost of the coverage and has separate eligibility and termination rules.

Dental benefits are completely separate from the Retiree Health and Welfare Medical Plan. You can enroll in the Medical Plan without enrolling in the dental plan; conversely, you can enroll in the dental plan without enrolling in the Medical Plan. The dental benefits are not described in this booklet - if you have enrolled in the dental plan or are interested in the details of the plan, you may request a separate dental brochure from the Fund Office website, www.carpenterfunds.com.

Medical Plan Choice

When you are eligible and you enroll, you may choose to be covered by the Indemnity Medical Plan and the prescription Drug coverage provided directly by the Fund, or by the Kaiser HMO plan. The Indemnity Medical Plan and prescription Drug coverage provided by the Fund are described in this booklet. The Kaiser HMO benefits are described a separate Evidence of Coverage available from Kaiser or from the Fund Office website, www.carpenterfunds.com.

You may choose to be covered by the Indemnity Medical Plan or by the Kaiser HMO plan. Your eligible Dependents will be enrolled in the same plan you choose for yourself.

Note: To be eligible for the Kaiser HMO, you must live in Kaiser's service area. If you are eligible for Medicare because you are age 65 or over or disabled, you will not be permitted to enroll in Kaiser unless you are enrolled in both Part A and Part B of Medicare and have assigned your Medicare benefits to Kaiser.

While recognizing the many benefits associated with this Plan, it is also important to note that not every expense you incur for health care is covered by this Plan.

All provisions of this document contain important information.

No individual shall have vested rights to benefits under this Plan. A vested right refers to a benefit that an individual has earned a right to receive and that cannot be forfeited. Health Plan benefits are not vested and are not guaranteed.

If you have any questions about your coverage or your obligations under the terms of your Plan, be sure to seek help or information. A Quick Reference Chart to sources of help or information about the Plan appears in this chapter.

Carpenters Health and Welfare Trust Fund for California is committed to maintaining health care coverage for Participants and their families at an affordable cost. However, because future conditions cannot be predicted, the Board of Trustees reserves the right to amend or terminate coverages at any time and for any reason. As the Plan is amended from time to time, you will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information.

Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

This Plan is established under and subject to the Federal law, Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA. The Indemnity Medical Plan (including mental health, substance abuse treatment, prescription Drugs and hearing aid benefits) of the Plan are self-funded with contributions from contributing employers and Eligible Participants held in a Trust. Kaiser HMO benefits of the Plan are fully insured with Kaiser.

The Kaiser HMO plan is provided through a contract between the Board of Trustees and Kaiser Foundation Health Plan.

The Indemnity Medical Plan (including mental health and substance abuse, prescription Drugs, vision, and hearing aid) benefits are not insured by any contract of insurance, and there is no liability on the part of the Board of Trustees or any individual or entity to provide payment over and beyond the portion of the Trust Fund designated for that purpose.

The Board of Trustees has the exclusive right and discretion to construe and interpret the Plan and is the sole judge of the standard of proof required for any Claim and the application and interpretation of the Plan. Any dispute as to eligibility, type, amount or duration of benefits or any right or Claim to payments from the Fund will be resolved by the Board or its duly authorized designee under and pursuant to the provisions of the Plan and the Trust Agreement, and its decision is final and binding upon all parties, subject only to judicial review as may be in harmony with Federal labor law. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Please note the Board has authorized the Fund Office to respond in writing to your written questions. If you have a question about your benefits, you should write to the Fund Office for a definitive answer. As a courtesy to you, the Fund Office may also respond informally to oral questions. However, oral information and answers are not binding upon the Board of Trustees and cannot be relied upon in any dispute concerning your benefits. Fund Office representatives have no authority to bind the Plan or to make any contractual agreements of any kind. Any information provided by the Fund Office is a courtesy and does not alter the provisions of the Plan.

Plan rules and benefits may be changed by the Board of Trustees from time to time. If this occurs, you will receive a written notice explaining the change. Please be sure to read all Plan announcement letters about benefit changes and keep them with this booklet. In order for you to be aware of the benefits available to you and your Dependents, we urge you to read this booklet carefully prior to obtaining medical care. If you have any questions about your benefits described in this booklet, please contact the Fund Office for assistance.

The Indemnity Medical Plan’s Utilization Review and Contract Provider programs (for Retirees and Dependents who are not eligible for Medicare) continue to be critical elements of our efforts to contain rising health care costs and we encourage you to become familiar with the Plan’s contract providers and Utilization Review programs.

Phrases with Special Meanings

If you see a word whose meaning you are unsure of, check the Definitions section in Article I of the Rules and Regulations that follow the SPD. It contains definitions of the words used in the SPD. Throughout this document, defined terms are capitalized.

However, because the following terms are so important, we are providing definitions here so that you understand the meaning of these terms when you see them in the SPD. For the complete legal definition of these terms, please refer to Article I of the Rules and Regulations.

Allowed Charge: For Emergency Services, Air Ambulance, or any service provided by a Non-Contract Provider at a Contract facility, the Allowed Charge is what is known as the "Recognized Amount". For more information about Recognized Amounts, see the description on the following page.

For all other services, the term "Allowed Charge" means the lesser of:

1. The dollar amount this Fund has determined it will allow for covered Medically Necessary services or supplies performed by Non-Contract Providers which may be an amount determined by an independent medical review firm or Anthem and the Blue Cross affiliates.
2. The Provider's actual billed charge.
3. An amount based on a percentage of the amount that would have been payable in accordance with Medicare's allowable payments.

The Plan limits Medically Necessary *outpatient* services from Non-Contract Providers who are not registered with the Centers for Medicare & Medicaid Services (CMS) to a maximum allowable charge of $200 per appointment, subject to the non-PPO deductible and coinsurance. Benefits paid *for in-patient* services from a Non-Contract Provider is based on a percentage of that provider's CMS registered fee; there will be no benefits available for in-patient services from a Non-Contract Provider who is not registered with CMS.

The amount charged by a provider may exceed the Fund's Allowed Charge and you may be responsible for any difference between the actual billed charge and the Fund's maximum Allowed Charge, in addition to any Copayment and percentage coinsurance required by the Plan.

Emergency Medical Condition: A medical condition, including a mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or, with respect to a pregnant woman, her unborn child in serious jeopardy.

Experimental or Investigational: This Plan relies on Anthem or another independent Review Organization to determine if a Drug, device or procedure is Experimental or Investigational. Experimental or Investigational means a Drug or device, medical treatment or procedure if:

1. The Drug or device cannot be lawfully marketed without approval of the United States Food and Drug Administration and approval for marketing has not been given at the time the Drug or device is furnished; or

2. The Drug, device, medical treatment or procedure, or the Patient informed consent document utilized with the Drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if Federal law requires such review or approval; or
3. **Reliable Evidence** shows that the Drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials, is the research, experimental, study or investigational arm of ongoing phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
4. **Reliable Evidence** shows that the prevailing opinion among experts regarding the Drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

For purposes of this definition, "Reliable Evidence" means only published reports and articles in peer-reviewed authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of 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.

Medically Necessary: With respect to services and supplies received for treatment of an Illness or Injury, and for the purpose of determining eligibility for Plan benefits, Medically Necessary services or supplies are those determined to be:

- Appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition; and
- provided for the diagnosis or direct care and treatment of the medical condition; and
- within standards of good medical practice within the organized medical community; and
- not primarily for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any Health Care Practitioner, or any Hospital or Specialized Health Care Facility. The fact that your Physician may provide, order, recommend or approve a service or supply **does not mean** that the service or supply will be considered Medically Necessary for the medical coverage provided by the Plan; and
- the most appropriate supply or level of service that can safely be provided. For Hospital stays, this means that acute care as a bed patient is needed due to the kind of services the patient is receiving or the severity of the patient's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting, as determined by the Professional Review Organization.

Services that are not Medically Necessary (except the routine preventive services specifically covered by the Plan) are not Allowed Charges.

This Plan relies on Anthem or another independent Review Organization to determine if a Drug, device or procedure is Medically Necessary.

Qualifying Payment Amount (QPA): The amount calculated using the methodology described in Centers for Medicare and Medicaid Services (CMS) regulations.

Recognized Amount: In order of priority, one of the following:

- An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
- an amount determined by a specified state law; or
- the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

For air ambulance services furnished by Non-Contract providers, Recognized Amount is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

Administrative Information

Prevailing Authority of Rules and Regulations

The provisions of the Plan are subject to and controlled by the legal Plan Document or Rules and Regulations. If there is a discrepancy between this Summary Plan Description (SPD) and the provisions of the Rules and Regulations, the provisions of the Rules and Regulations will govern. The Rules and Regulations are printed at the back of this SPD and are also available on the Fund's website (www.carpenterfunds.com).

Non-Discrimination Policy

The Carpenters Health and Welfare Trust Fund for California complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Grandfathered Health Plan Under the Patient Protection and Affordable Care Act (The Affordable Care Act)

The Indemnity Medical Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at (888) 547-2054 or (510) 633-0333.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or https://www.dol.gov/agencies/ebsa/laws-and regulations/laws/affordable-care-act. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Important Contact Information

The Plan is sponsored and administered by the Board of Trustees of the Carpenters Health and Welfare Trust Fund for California. However, the Trustees have delegated administrative responsibilities to other organizations as follows:

- Fund Office:
    1. Maintains eligibility records;
    2. accounts for self-payment contributions;
    3. administers Indemnity Medical and Hearing Aid benefits;
    4. answers Participant inquiries; and
    5. handles other routine administrative functions.
- Kaiser Foundation Health Plan offers a Health Maintenance Organization (HMO) plan for medical, prescription Drug, hearing aid and vision benefits.
- Indemnity Medical Plan
    6. **Anthem Blue Cross of California** provides access to a Contract Provider network for Indemnity medical benefits and provides the Plan's utilization review program for certain medical benefits (applicable only to Retirees and Dependents not eligible for Medicare).
    7. **Express Scripts** provides access to contract pharmacies and administers the Plan's mail service program and Accredo specialty pharmacy program.
    8. **Vision Service Plan (VSP)** administers vision benefits and provides access to Contract Providers for vision benefits.
- **Delta Dental PPO and DeltaCare USA** provide voluntary dental benefits to retirees who choose to purchase coverage.

When you need information, please check this document first. If you need further help, call the individuals listed in the following Quick Reference Chart:

►When to Contact the Fund Office	
When you have questions about: eligibility, benefits, COBRA Continuation Coverage, self-payment contributions and other routine administrative functions.	Direct Line: (510) 633-0333 Toll Free: (888) 547-2054 Email: benefitservices@carpenterfunds.com www.carpenterfunds.com
►Who to contact if you have questions about your Indemnity Medical Plan	
Claims and appeals for the Indemnity Medical Plan	Carpenter Funds Administrative Office Direct Line: (510) 633-0333 Toll Free: (888) 547-2054 Email: benefitservices@carpenterfunds.com www.carpenterfunds.com
Indemnity Medical Plan benefits	
Hearing Aid Benefits for the Indemnity Medical Plan	
Medicare Part D Notice of Creditable Coverage	
Summary of Benefits and Coverage (SBC)	
HIPAA Privacy and Security	

►Who to contact if you have questions about your Indemnity Medical Plan	
Finding a contract provider (for Non-Medicare Retirees and Dependents covered under the Indemnity Medical Plan)	Inside California: **Anthem** (800) 810-2583 www.anthem.com Outside California: **Blue Card** (800) 810-2583 www.bcbs.com
For assistance with non-Emergency medical questions	**Anthem** 24/7 Nurse Line (800) 700-9184
Review Organization for Required Utilization Review – In or Outside California (for Non-Medicare Retirees and Dependents)	**Anthem** (800) 274-7767 (Physicians Only)
Prescription Drugs - Network Pharmacy, Mail Service and Specialty Pharmacy Services (Kaiser HMO Participants should contact Kaiser for information about prescription Drug benefits)	**Express Scripts** (800) 939-7093 www.express-scripts.com (800) 282-2881 (to order refills) (800) 753-2851 (for doctors to request Utilization Review) Medicare Eligible Participants: Call (800) 311-2757 for assistance
Vision benefits for the Indemnity Medical Plan	**Vision Service Plan (VSP)** (800) 877-7195 www.vsp.com
LiveHealth Online	www.livehealthonline.com

►Who to contact if you have questions about your Kaiser HMO benefits
Kaiser Member Services (800) 464-4000 www.kp.org

►Who to contact if you have questions about your COBRA Continuation Coverage
Fund Office Direct line: (510) 633-0333, Toll Free: (888) 547-2054 Email: benefitservices@carpenterfunds.com www.carpenterfunds.com

►Who to contact if you have questions about optional Dental Benefits
Delta Dental (PPO) (800) 765-6003 www.deltadentalins.com DeltaCare USA Customer Relations (800) 422-4234

►Who to contact if you have questions about the Health Insurance Marketplace
Residents of California: Covered California www.coveredca.com **Residents of Other States: Health Insurance Marketplace** www.healthcare.gov

►Who to contact if you have questions about your Medicare Coverage
Please call Medicare at 1-800-MEDICARE (1-800-633-4227) TTY users should call 1-877-486-2048.

Enrollment and Eligibility

Enrollment in the Retiree Plan

Proper enrollment is required for coverage under this Plan. Enrollment forms can be completed online at www.carpenterfunds.com or by obtaining a paper form from the Fund Office. If enrollment has been requested but proper enrollment (including submission of supporting documents) has not been completed, eligibility under the Plan and Claims will not be able to be considered for payment until such proper enrollment has been completed and received by the Fund Office.

You must remain with the carrier (Indemnity or Kaiser) you have elected for at least 12 months (unless you are enrolled with Kaiser and you move out of the service area). After 12 months, you may change to another carrier by submitting a new enrollment form indicating the change to the Fund Office.

Any change in carriers will be effective on the later of the first day of the second calendar month following the date:

- The enrollment form is received by the Fund Office; or
- the date a prepaid plan confirms enrollment in or disenrollment from a Medicare Risk plan.

Enrollment in Medicare

If you are receiving Social Security retirement benefits when you turn age 65, you will be enrolled in Part A of Medicare automatically; however, you must enroll in Medicare Part B. For most Americans, Medicare Part A is provided at no cost, but you must pay for Part B benefits even when you are enrolled in Carpenter Funds Retiree Health and Welfare. Medicare Plan A and Plan B enrollment is a critical part of your overall health benefit.

> If you have questions about Medicare, visit www.medicare.gov or call (800) 633-4227 (TTY users: (877) 486-2048)

Plan type, according to Medicare

As with all Carpenter Funds Health and Welfare Plans, Medicare-eligible Participants have two medical Plan choices – Indemnity or Kaiser. There are important distinctions in how these plans interact with Medicare.

The Indemnity Medical Plan for Medicare-eligible Participants is considered a **supplemental** plan; this means Participants retain their Medicare Plan A and Plan B benefits, and the Carpenters Indemnity Plan provides additional coverage on top of Medicare.

The Kaiser HMO plan is different; it's called a Medicare Advantage plan. That means Participants who choose Kaiser assign all their Medicare benefits to Kaiser, and Kaiser Senior Advantage **replaces** traditional Medicare.

Indemnity Plan	Kaiser Senior Advantage
Medicare Supplement	Medicare Advantage (Replacement)
Medicare Part A	Comprehensive coverage, including Medicare Parts A&B, Prescription Drugs and Vision
Medicare Part B	
Indemnity Medical Plan	
Express Scripts (Prescription Drugs)	
VSP (Vision)	

Indemnity Plan: If you postpone receiving Social Security you still must apply for Part A and Part B of Medicare. If you are receiving Social Security, you will be automatically enrolled in Medicare Part A. Whether you are receiving Social Security retirement benefits or not, you still need to apply for Medicare Part B. Contact the nearest Social Security Administration office in the 3 months before you turn age 65 to enroll in both Medicare Parts A and B. By enrolling promptly, you will avoid a possible delay in the start of your coverage and a possible increase in the premium you will have to pay for Part B.

Failure to enroll in both parts of Medicare could create serious financial hardship for you. On the first day of the month you become eligible for Medicare, the benefits payable by the Indemnity Plan will be limited to the Medicare supplemental benefits described on page 24 regardless of whether you have actually enrolled for Medicare and regardless of whether Medicare makes any payment. This means that the Plan will pay only 20% for services normally covered by Part B of Medicare and only the Medicare inpatient hospital deductible amount if you are hospitalized.

Kaiser HMO: Members eligible for Medicare must also enroll in Medicare, and are required to assign the Medicare benefits to Kaiser Senior Advantage. If you are an HMO member who is eligible for Medicare and you do not enroll in both Medicare Parts A and B or do not assign your Medicare benefits to the Kaiser Senior Advantage program, your coverage in Kaiser will be terminated. In this case, you and your Dependents may be allowed to enroll in the Indemnity Plan if neither person is enrolled in Kaiser Senior Advantage; however, the Indemnity Plan will pay as though you had enrolled in both parts of Medicare. Please note that even though you have assigned your Medicare benefits, you are still responsible for Medicare Part B premiums.

If you and your Spouse are enrolled in Retiree Health and Welfare and you become eligible for Medicare before your Spouse, your Spouse will continue to be covered by the Retiree benefits for non-Medicare eligible beneficiaries until he/she becomes eligible for Medicare. If your Spouse becomes eligible for Medicare before you, your Spouse is required to enroll in Medicare Part A and Part B and receive Medicare supplemental benefits and you will continue to be covered by the non-Medicare benefits until you become eligible for Medicare.

Proof of Dependent Status

Specific documentation to substantiate Dependent status is required by the Plan, and may include a birth certificate, marriage certificate, proof of the Dependent's age, the Dependent's social security number, and participation in any Dependent audit. Below are items the Plan may request to substantiate Dependent status. **Note that failure to provide timely proof of Dependent status means that Claims**

submitted to the Plan for your Dependents may not be considered for payment until such proof is provided. Please also note that you must notify the Fund Office of any changes to Dependent status.

- **Spouse:** The certified marriage certificate.
- **Child:** The certified birth certificate showing the child is the biological child of the Retiree.
- **Stepchild:** The certified birth certificate of the child and marriage certificate of biological parent.
- **Child by Adoption or placement for adoption**: Court order paper signed by the judge showing that the Retiree has adopted or intends to adopt the child.
- **Legal Guardianship:** The court-appointed legal guardianship documents and certified birth certificate and proof that the child is considered your Dependent for Federal income tax purposes.
- **Disabled Dependent Child:** Current written statement from the child's Physician indicating the Dependent child is currently prevented from earning a living and primarily dependent on the Participant for financial support due to a medical condition, provided the child had such condition and was eligible as a Dependent under this Plan before reaching the Limiting Age.
- **National Medical Support Notice for Qualified Children:** A National Medical Support Notice (NMSN) or Qualified Medical Child Support Order (QMCSO) signed by a judge.
- **Domestic Partner**: Documentation that the Retiree Participant has registered with the individual as a Domestic Partner with any state or local government agency authorized to perform such registrations.
- **Domestic Partner Child**: The certified birth certificate showing the child is the biological child of the Domestic Partner and enrollment of the Domestic Partner.
- **Students**: Full-time students of guardianship children or children of Domestic Partners from age 19 to age 23 with proof of full-time student status from an accredited institution.

Dependent Social Security Numbers Needed

To comply with Federal Medicare coordination of benefit regulations and certain IRS reporting rules, you must promptly furnish to the Trust Fund the Social Security Number (SSN) of your Eligible Dependents for whom you have elected, or are electing, Plan coverage, and information on whether you or any of such Dependents are eligible and are currently enrolled in Medicare or have disenrolled from Medicare. This information will be requested when you first enroll for Plan coverage but may also be requested at a later date.

If a Dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: http://www.socialsecurity.gov/online/ss-5.pdf. Applying for a social security number is free.

Failure to provide the SSN or failure to complete the CMS model form means that Claims for eligible individuals may not be paid for the affected individuals. The CMS model form is available from the Fund Office or http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Downloads/New-Downloads/RevisedHICNSSNForm081809.pdf.

Retiree Eligibility

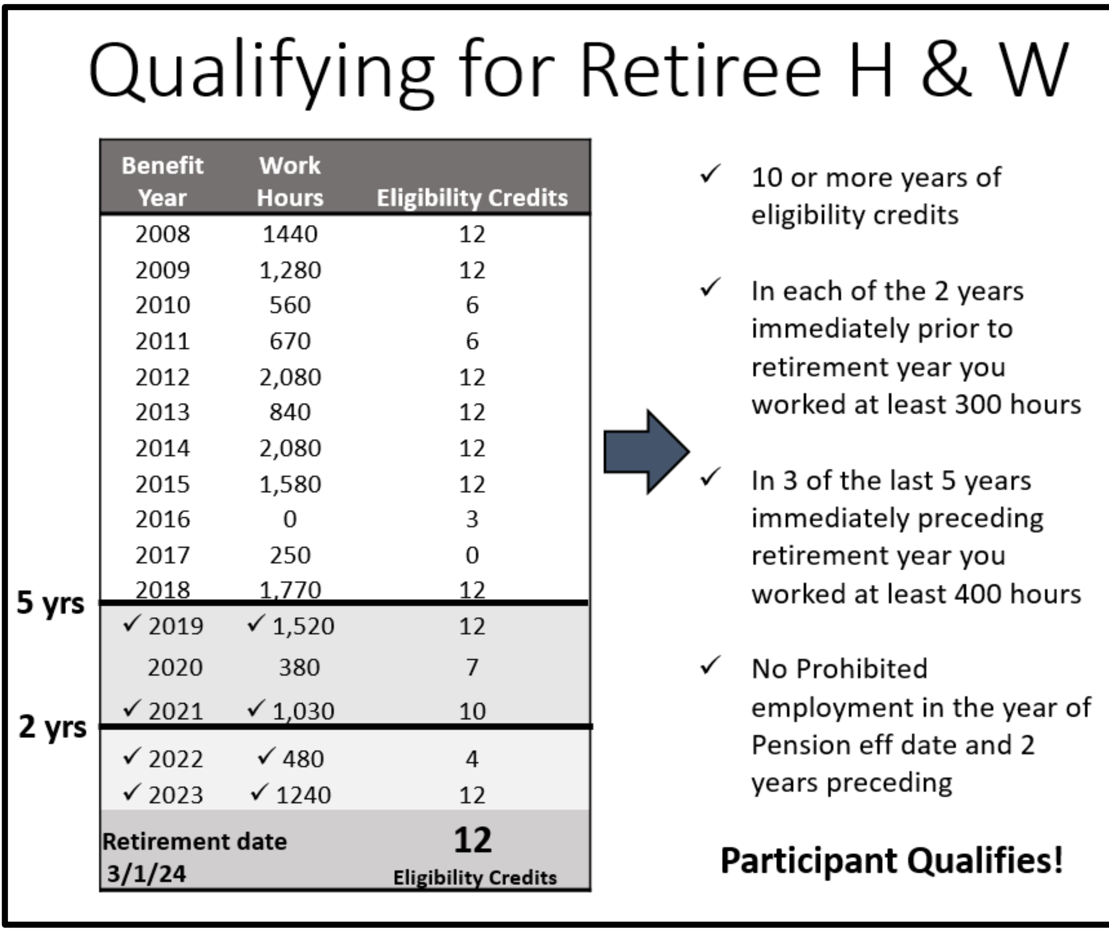
Eligibility requirements are described on the following pages. Please read the important information below regarding enrollment in this Plan and enrollment in Medicare.

You are eligible for health and welfare benefits if you meet **each** of the following five (5) requirements:

1. You must be in receipt of pension benefits from the Carpenters Pension Trust Fund for Northern California or a related plan (listed below) that is based on 10 or more years of eligibility credit, based on Hours of Work or Qualified Military Service. You may use qualifying hours from any of the following plans to satisfy the 10 years of eligibility credit requirement:
   - Carpenters Pension Trust for Northern California
   - Carpenters Fund Administration Office Staff Plan
   - Any Lathers Plan merged into the Carpenters Pension Trust Fund for Northern California
   - OPEIU Local 3 or 29 (if service was with a Contributing Employer)
   - Industrial Carpenters Pension Plan
   - Any pension plan when required by a Collective Bargaining Agreement and/or Memorandum of Understanding negotiated by the Carpenters 46 Northern California Counties Conference Board and/or any of its affiliates
2. In each of the 2 calendar years immediately preceding the calendar year in which your pension effective date occurred, you worked at least 300 hours in covered employment for a Contributing Employer, during which time contributions were required to be paid into the Active Employees' Plan A, Plan B, or Plan R.

   For purposes of the above 300-hour provision, you may count hours worked in the year of retirement even if you do not work a full calendar year. You may also count hours of disability credit granted under the provisions of the active employees' Plan, hours of disability credit granted under the provisions of the Carpenters Pension Trust Fund for Northern California, and hours worked for a contributing employer in the Southwest Carpenters Health and Welfare Plan.
3. In 3 of the last 5 calendar years immediately preceding the calendar year in which your pension effective date occurred, you worked at least 400 hours per year in covered employment for a Contributing Employer, during which time contributions were required to be paid into the Active Employees' Plan A, Plan B, or Plan R. For purposes of this 400-hour requirement, you can count hours worked in the year of retirement even if you do not work a full calendar year. **Hours of disability credit may not be used to satisfy this requirement**.
4. You did not engage in any hours of work for wages or profit in the Building and Construction Industry for an entity that was not a Contributing Employer to the active employees' Plan, or not a contributing employer to a related plan that is signatory to the International Reciprocal Agreement for Carpenters Health and Welfare Funds (including self-employment) during the calendar year in which you pension effective date occurred, **and** in each of the 2 immediately preceding calendar years.
5. You make the required self-payments in the form and manner designated by the Board of Trustees.

In the example below, a Participant fulfilled all requirements for Retiree Health and Welfare eligibility:



Benefit Year	Work Hours	Eligibility Credits
2008	1440	12
2009	1,280	12
2010	560	6
2011	670	6
2012	2,080	12
2013	840	12
2014	2,080	12
2015	1,580	12
2016	0	3
2017	250	0
2018	1,770	12
✓ 2019	✓ 1,520	12
2020	380	7
✓ 2021	✓ 1,030	10
✓ 2022	✓ 480	4
✓ 2023	✓ 1240	12
Retirement date 3/1/24		12 Eligibility Credits

Please note: This is only an example, and every Participant has a unique work history and experience.

When Retiree Participation Begins

If you are a Retiree who meets the requirements discussed above, your participation in this Plan will begin after the first day of retirement on the earlier of:

1. The 4th month following your date of retirement or,
2. The first day of the month following exhaustion of eligibility provided by your Hour Bank under the active employees' Plan.

Cancellation of Active Hour Bank: Your hour bank under the active Plan will be cancelled if you are eligible for Retiree Health and Welfare coverage on the first day of the 4th month following your retirement, regardless of whether or not you elect to enroll for coverage as a Retired Participant, and even if you delay enrolling for Retiree health coverage because you have other health coverage available. Additionally, the hour bank under the active Plan for a stakeholder (as defined by the active Plan), will be cancelled if the stakeholder's employer stops reporting hours but the individual remains in the employ of the employer in any capacity on the first day of the second month.

For example: If you retired on March 1 and had an active Plan hour bank balance of 600 hours (6 months of future eligibility under the Active Carpenters Health and Welfare Trust Fund for California), your Retiree coverage would begin on June 1. (June 1 would be the first day of the fourth month following your date of retirement and would be **earlier** than the end of the 6 months of eligibility provided by your active hour bank.)

If you retired on March 1 and had an active Plan hour bank balance of 200 hours (2 months of future eligibility under the Active Carpenters Health and Welfare Trust Fund for California), your Retiree coverage would begin on May 1. (The end of the 2 months of eligibility provided by your active Plan hour bank would be **earlier** than the first day of the fourth month following your date of retirement.)

Termination of Eligibility

Your eligibility will terminate on the *earlier* of the following dates:

- At the end of the last month for which a pension benefit is payable to you from the Carpenters Pension Trust Fund for Northern California or one of the related plans mentioned under "Retiree Eligibility" on page 10, *including a suspension of pension benefit payments*, or
- At the end of the month for which your last self-payment was received by the Trust Fund.

Extended Eligibility for Surviving Dependents of Deceased Retirees

The Plan has the following provisions for extended eligibility for your Dependents in the event of your death:

- **Extension for Spouse only:** If you were receiving a joint and survivor pension at the time of your death and you have a surviving Spouse who will receive the Spouse's portion of that pension, he or she may continue eligibility for himself or herself only, provided the required self-payment is made.
- **Extension for Spouse and Dependent children** (whether you are receiving your pension in the joint and survivor pension payment form or some other payment form): If you die before receiving pension benefits (other than a disability pension) for at least 60 months, your Spouse and eligible Dependent children may continue their eligibility for the remainder of the 60-month period, provided the required self-payment is made. If you are receiving a disability pension or a reciprocal disability pension and you die before receiving benefits for at least 36 months, your Spouse and eligible Dependent children may continue their eligibility for the remainder of the 36-month period, provided the required self-payment is made. In either case, if your Spouse remarries prior to the termination of pension payments, coverage under this extension will terminate on the date of remarriage.

Extended Benefits for Inpatient Hospital, Skilled Nursing Facility or Home Care

If you are receiving Plan benefits for inpatient Hospital, Skilled Nursing Facility or Home Health Care on the date coverage ends because of a loss of eligibility, you will continue to receive benefits for that care until you are discharged from the Hospital or Skilled Nursing Facility or your covered home health care is completed.

These extended benefits are subject to the same terms that would have applied if this coverage had remained in force.

When the Plan Can End Your Coverage for Cause (Rescission)

In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage (a rescission) except when self-payments are not paid in a timely manner; or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan. Keeping an ineligible dependent enrolled under the Plan (for example, an ex-Spouse, over-age or ineligible dependent child, etc.) is considered fraud. Other situations of fraud or intentional misrepresentation of fact can include: failure to submit the required proof of Dependent status documentation or the documentation submitted does not confirm the dependent is eligible as a dependent for coverage under this Plan. The Plan will provide at least 30 days' advance written notice to each Participant who will be affected before coverage is rescinded.

Engagement in Employment

The following rules will apply if you engage in a type of work that requires contributions to the active employees' Plan, provided that work does not result in the suspension of benefit payments from the Carpenters Pension Trust Fund for Northern California:

You will not establish eligibility under the active employees' Plan regardless of the number of hours worked. However, if you work enough consecutive hours that in the absence of this rule you would have qualified for eligibility under the active employees' Plan, 50% of the health and welfare contributions paid to the active employee's Plan on your behalf will be used to offset your self-pay contributions for Retiree health coverage.

This offset will be granted for 50% of your employer contributions up to a maximum of 480 hours in a calendar year, limited to the amount of your Retiree coverage self-pay amount less any other rebate provided by the Plan.

If you are not an eligible Retired Employee in this Plan, or if the hours worked are less than the number required to earn eligibility under the active Employee's Plan in the absence of this rule, no health and welfare contributions will be credited on your behalf.

Dependents' Eligibility

If you elect coverage for yourself, you can also enroll your eligible Dependents on the later of the day you become eligible for your own coverage or the day you acquire an eligible Dependent, either by marriage, Domestic Partnership, birth, adoption or placement for adoption, but only if you have submitted a completed written enrollment form, provided the Plan's required proof of Dependent status and made the required self-payments. The enrollment form may be obtained from the Fund Office and required proof of Dependent status must be received by the Fund Office in the timeline spelled out in the Plan guidelines.

A Dependent may not be enrolled for coverage unless the Retiree is also enrolled (except as a surviving Dependent of a deceased Retiree). Specific documentation to substantiate Dependent status is required by the Plan. An eligible Dependent includes:

- Your lawful Spouse;
- your qualified Domestic Partner (as defined below);
- your child who is:

1. A natural child, stepchild, legally adopted child, or a child that is required to be covered under a National Medical Support Notice or Qualified Medical Child Support Order, who is younger than 26 years of age, whether married or unmarried. Adopted children are eligible under the Plan when they are placed for adoption.
2. An unmarried child for whom you have been appointed legal guardian, provided the child is younger than 19 years of age and is considered your Dependent for Federal income tax purposes;
3. an unmarried child of your qualified Domestic Partner, provided the child is younger than 19 years of age and is primarily dependent on you for financial support;
4. an unmarried child eligible under paragraph (2) or (3) above who is at least 19 but less than 23 years of age and a full time student at an accredited educational institution, provided the child otherwise meets the requirements of paragraph (2) and (3) above; or
5. an unmarried child of you or your spouse or qualified Domestic Partner of any age who is prevented from earning a living and primarily dependent on you for financial support due to a mental or physical disability and submits written documentation by their Physician to support his or her condition and provided the child had such condition while an eligible Dependent under this Plan before reaching the Limiting Age described in paragraphs (1), (2), (3) or (4) above.

For children of a Domestic Partner or children who are covered under a legal guardianship: If the Plan receives a written certification from a child's treating Physician that (1) the child is suffering from a serious illness or injury, and (2) a leave of absence (or other change in enrollment) from a postsecondary institution is Medically Necessary, and if the loss of student status would result in a loss of health coverage under the Plan, the Plan will extend the child's coverage for up to one year. This maximum one-year extension of coverage begins on the first day of the Medically Necessary leave of absence (or other change in enrollment) and ends on the date that is the earlier of (i) one year later, or (ii) the date on which coverage would otherwise terminate under the terms of the Plan (for example, when the child reaches the Plan's Limiting Age). You or your Dependent must submit a Physician's certification of the medical necessity for the leave to the Fund Office at least 30 days prior to the medical leave of absence if it is foreseeable, or 30 days after the start of the leave of absence in any other case.

National Medical Support Notice (NMSN) or Qualified Medical Child Support Orders (QMCSO): In accordance with ERISA Section 609(a), the Fund will provide coverage for a child of a Participant if required by a Qualified Medical Child Support Order, including a National Medical Support Notice (NMSN). A QMCSO or NMSN will supersede any requirements in the Plan's definition of Dependent stated above. The Plan will enroll as directed by the Order any child of a Plan Participant specified by the Order. A *Qualified Medical Child Support Order* is any judgment, decree or order (including approval of a domestic relations settlement agreement or National Medical Support Notice) issued by a court that:

- Provides the child of a Plan Participant with child support or directs the Participant to provide the child with coverage under a health benefits plan; or
- enforces a state law relating to medical child support pursuant to Section 1908 of the Social Security Act, which provides in part that if the Participant parent does not enroll the child, then the non-Participant parent or State agency may enroll the child.

When in receipt of a QMCSO or NMSN, the Fund is required to enroll the child(ren) in the Plan.

A Medical Child Support Order will not qualify if it would require the Plan to provide any type or form of benefit or any option not otherwise provided

under this Plan, except to the extent necessary to comply with Section 1908 of the Social Security Act.

No eligible Participant's child covered by a Qualified Medical Child Support Order will be denied enrollment on the grounds that the child is not claimed as a dependent on the parent's Federal income tax return or does not reside with the parent.

Procedures governing NMSN or QMCSO are available from the Fund Office free of charge.

Qualified Domestic Partners*:* The term "Qualified Domestic Partner" means a person whose relationship with the Participant meets the following requirements:

- A person who the Participant has registered with as a Domestic Partner by any state or local government agency authorized to perform such registrations.
- Any prior domestic partnership of the Participant has been terminated not less than 6 months prior to the date of enrollment of the subsequent Domestic Partner.
- Application for Domestic Partnership with the Participant is properly made as required by the Board of Trustees and all required taxes on the imputed income attributable to Domestic Partner benefits are paid to the Fund when due.

Note: following the Fund Office's receipt of the enrollment documents to enroll an eligible Domestic Partner (including, if applicable, eligible children of a Domestic Partner), such Dependent(s) will begin participation in the Plan effective on the first day of the second month following the Fund Office's receipt of the enrollment documents.

The following chart outlines the Fund's rules for Dependent eligibility:

Dependent	Limiting Age and/or Eligibility Requirements	Documentation Required
Spouse	Legally married	• Certified marriage certificate; • if applicable, divorce decree from former Spouse; and • Social Security number (or tax identification number).
Domestic Partner	Must be a qualified Domestic Partner	• Proof of registry as a Domestic Partner by any state or local government agency; Social Security number (or tax identification number); and • payment of imputed taxes.
Natural child	Younger than age 26	• Certified birth certificate showing biological child of the Retiree; and • Social Security number (or tax identification number).
Stepchild	Younger than age 26	• Certified birth certificate; • divorce decree from former Spouse, if applicable; • marriage certificate; and • Social Security number (or tax identification number).

Dependent	Limiting Age and/or Eligibility Requirements	Documentation Required
Legally adopted child (or placed for adoption)	Younger than age 26	• Court order paper signed by the judge showing that the Retiree -has adopted or intends to adopt the child (placed for adoption); • Social Security number (or tax identification number).
Children who are required to be covered due to a Qualified Medical Child Support Order (or under a National Medical Support Notice)	Younger than age 26 (or when the QMCSO or National Medical Support Notice terminates)	• A National Medical Support Notice (NMSN) or Qualified Medical Child Support Order (QMCSO) signed by a judge; and • Social Security number (or tax identification number).
Children of a Domestic Partner	• Younger than age 19; • primarily dependent on the Retiree for financial support; and • younger than age 23 if a full-time student at an accredited educational institution.	• Certified birth certificate showing the child is the biological child of the Domestic Partner; • proof of financial dependency; • Social Security number (or tax identification number); and • payment of imputed taxes. • In addition, full-time students of who are children of Domestic Partners from age 19 to age 23 must provide proof of full-time student status from an accredited institution.
Children who are required to be covered under a legal guardianship:	• Younger than age 19; • must be considered the Retiree's Dependent for Federal income tax purposes; and • younger than age 23 if a full-time student at an accredited educational institution.	• Court-appointed legal guardianship documents; • certified birth certificate; • proof that the child is considered your Dependent for Federal income tax purposes; and • Social Security number (or tax identification number). In addition, guardianship children from ages 19 to age 23 must provide the Fund with proof of full-time student status from an accredited institution.
Mentally or Physically disabled child	• No Limiting Age if the Dependent qualifies as a disabled child and is: • unmarried; • prevented from earning a living because of mental or physical disability; • was eligible as a Dependent under the Plan prior to the Limiting Age; and • primarily dependent on the Retiree for financial support.	• Documentation from child's Physician stating the child is incapable of earning a living due to mental or physical disability; • documentation confirming that the disabled child is primarily dependent upon the Retiree for financial support; and • Social Security number (or tax identification number).

The Plan's coverage of adult children over the age of 18 does not create any parental responsibility to providers for Coinsurance, Deductibles or otherwise unpaid services provided to an adult child.

When Dependent Participation Begins

Your eligible Dependents become eligible under the Plan on the same date you do. If you get married or have a new Dependent child after you first become eligible, your new Dependent(s) will begin their eligibility on the date they became your Dependent, provided you enroll your Dependents in a timely manner (new Spouse within 60 days after the date of marriage; new child within 60 days of the child's birth or adoption or the date you became the child's legal guardian). Please note, if you did not elect Retiree Health and Welfare coverage when first eligible, you must enroll yourself and eligible Dependents within 31 days of marriage, birth, or adoption.

Termination of Eligibility for Dependents

Dependents' eligibility will terminate:

- On the date the Participant's eligibility terminates or, in the event of the death of the Participant, on the date his or her eligibility would have terminated but for this death; or
- on the date he or she no longer qualifies as a Dependent, except that eligibility for Dependent natural children, stepchildren and legally adopted children will terminate at the end of the month in which the Dependent turns age 26; or
- on the date you stop making the required self-payments for a Dependent's coverage.

Medicare

If you or your Spouse are not eligible for Medicare when you first retire, you may delay enrolling in the Plan until you or your Spouse become eligible for Medicare. You must request enrollment with the Fund Office ***within 90 days*** of you or your Spouse becoming entitled to Medicare.

Late Enrollment Rules

Newly Acquired Spouse and/or Dependent Child(ren)

- If you delay enrollment in the Plan when you initially retire and subsequently become married, enter into a Domestic Partnership, or have a child(ren) by birth, adoption or placement for adoption, you may request enrollment for yourself and your new Spouse, Domestic Partner and/or any Dependent child(ren) no later than 31 days after the date of marriage, date of entry into a Domestic Partnership, or birth, adoption or placement for adoption. (Note: A child is "Placed for Adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.)
- If you are enrolled in the Plan and then acquire a Spouse by marriage, enter into a Domestic Partnership or acquire any Dependent child(ren) by birth, adoption or placement for adoption, you may request enrollment for your new Spouse and/or any Dependent child(ren) within 60 days after the date of marriage, birth, adoption or placement for adoption.

Loss of Other Coverage

You may delay enrollment in the Plan when you initially retire and can complete enrollment 'delay form' because you, your Spouse, and/or any Dependent child(ren) had health care coverage under another group health plan or health insurance policy (including COBRA Continuation Coverage, individual health insurance, Medicare, Marketplace or other public program).

If you, your Spouse and/or any Dependent child(ren) **loses coverage** under that other group health plan or health insurance policy; and you are eligible for coverage under this Plan, you may request enrollment

for yourself and/or your Spouse and/or any Dependent child(ren) within **31 days** after the termination of their coverage under that other group health plan or health insurance policy.

If you or your Dependent delay coverage under this Plan because you are covered under the Affordable Care Act Health Insurance Marketplace or state exchange, you may re-enroll in this Plan ***within 31 days*** of the date the other coverage ceases.

You are not eligible if you choose to terminate your other group coverage. You are only eligible If that other coverage is terminated because of:

- Loss of eligibility for that coverage including loss resulting from divorce, death, voluntary or involuntary termination of employment or reduction in hours (this does not include loss due to failure of Participant to pay premiums on a timely basis or termination of the other coverage for cause); or
- termination of employer contributions toward that other coverage (your employer must cease all contribution toward coverage; your employer's reduction of contributions does not trigger a special enrollment right); or
- the health insurance that was provided under COBRA Continuation Coverage, and such COBRA coverage was **"exhausted;"** or
- moving out of an HMO service area if HMO coverage terminated for that reason and, for group coverage, no other option is available under the other plan.

COBRA Continuation Coverage must be "exhausted". You may not choose to terminate COBRA coverage early in order to enroll for coverage under the Retiree Health and Welfare Plan. COBRA Continuation Coverage is **"exhausted"** if it ceases for any reason other than either the failure of the individual to pay the applicable COBRA premium on a timely basis, or for cause (such as making a fraudulent Claim or an intentional misrepresentation of material fact in connection with that COBRA Continuation Coverage). Exhaustion of COBRA Continuation Coverage can also occur if the coverage ceases:

- Due to the failure of the employer or other responsible entity to remit premiums on a timely basis;
- when the employer or other responsible entity terminates the health care plan and there is no other COBRA Continuation Coverage available to the individual;
- when the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not by the choice of the individual) and there is no other COBRA Continuation Coverage available to the individual; or
- because the 18-month, 29-month, or 36-month (as applicable) period of COBRA Continuation Coverage has expired.

Medicaid or a State Children's Health Insurance Program (CHIP):

When you are eligible for benefits under this Plan but delayed your enrollment, you and your Dependents **may enroll in this Plan** if you (or your eligible Dependents):

- Have coverage through **Medicaid or a State Children's Health Insurance Program (CHIP)** and you (or your Dependents) **lose eligibility for that coverage**. However, you must request enrollment in this Plan within **60 days** after the Medicaid or CHIP coverage ends; or
- become **eligible for a premium assistance program through Medicaid or CHIP**. However, you must request enrollment in this Plan within **60 days** after you (or your Dependents) are determined to be eligible for such premium assistance.

Start of Coverage for Special Enrollment:

- **Coverage for an individual enrolling because of loss of other coverage or because of marriage:** If the individual requests Special Enrollment within the timeline described above, coverage will become effective on the first day of the month following the other plan's termination date or the date of marriage, whichever is later.
- **Coverage for Special Enrollment related to Medicaid or State Children's Health Insurance Program (CHIP):** If the individual requests enrollment within 60 days of the date of the Special Enrollment opportunity related to Medicaid or a State Children's Health Insurance Program (CHIP), generally coverage will become effective on the first day of the month following the date of the event.
- **Coverage of a newborn or newly adopted newborn Dependent Child** who is properly enrolled within 31-days after birth will become effective as of the date of the child's birth.
- **Coverage of a newly adopted Dependent Child or Dependent Child Placed for Adoption** who is properly enrolled more than 31 days after birth, but within 31 days after the child is adopted or placed for adoption, will become effective as of the date of the child's adoption or placement for adoption, whichever occurs first.
- **Individuals enrolled during Special Enrollment** have the same opportunity to select Plan benefit options at the same costs and the same enrollment requirements as are available to similarly-situated Participants at initial enrollment.

If You Elected COBRA Continuation Coverage

If you elected to continue your active employee benefits for 18 months under COBRA when you retired, your participation in this Retiree Plan will start the first day of the month following the date you have exhausted the maximum duration of COBRA Continuation Coverage.

Re-Enrollment after Terminating Coverage

If you and/or your Spouse enrolled in the Plan and subsequently terminated coverage under this Plan because you became covered under an employer's health plan, the Affordable Care Act Health Insurance Marketplace or state exchange if not eligible for Medicare, or under another employer or trust fund Medicare Advantage contract, you may re-enroll in this Plan ***within 31 days*** of the date the other coverage ceases. In order for a Spouse to enroll in the Plan, the Retiree must also be enrolled, except in the case of a surviving Spouse.

If you and/or your Spouse enrolled in the Plan and subsequently terminated coverage under this Plan because you became covered under an individual plan, including an individual Medicare supplemental plan or Medicare Advantage plan that is not associated with the Affordable Care Act health insurance marketplace or state exchange, you will not be permitted to re-enroll in the Carpenters Retiree Health and Welfare Plan.

Options for Dependents of a Retiree When Coverage Ends

When Dependent coverage under this Plan terminates you may have the option to buy temporary continuation of this group health Plan coverage by electing COBRA (for Dependents of a Retiree), or you can look into your options to buy an individual insurance policy for health care coverage from the **Health Insurance Marketplace** as outlined in the COBRA section of this booklet.

COBRA: Continuation of Coverage Under Federal Law

(This COBRA Continuation Coverage does not apply to Domestic Partners or children of Domestic Partners. Refer to page 36 for Domestic Partner provisions.)

Under Federal law known as COBRA, the Trust Fund is required to offer Dependents of a Retiree the opportunity for a temporary continuation of health coverage in certain circumstances where coverage under the Plan would otherwise terminate.

Please note: COBRA coverage under this Plan is for Dependents only.

Dependents of a Retiree covered under this Plan, who have a Qualifying Event that results in a loss of coverage, have the right to continue health coverage that was in effect at the time of the Qualifying Event. To receive this Continuation Coverage, monthly premiums must be paid to the Fund.

Qualifying Events

The following are COBRA Qualifying Events**:**

1. The death of the Retiree;
2. A divorce of the Retiree and Spouse; or
3. Cessation of Dependent child's dependent status.

Duration of COBRA Coverage

COBRA coverage can continue generally for up to 36 months. The 36 months will be offset by any extended coverage provided.

Cost of Continuation Coverage – Benefits That May Be Continued

COBRA Continuation Coverage is available only at the expense of the person enrolling which may include eligible Dependents. If you or your Dependent elect to continue coverage for that Dependent, the full cost, plus a 2% administrative fee will be charged.

You may elect to continue:

- Medical and prescription Drug coverage only; or
- medical, prescription Drug, and vision coverage.

Paying for COBRA Coverage

The Fund Office will notify you of the cost for the coverage at the time you receive your notice of entitlement to COBRA coverage and of any monthly COBRA premium amount changes.

There will be an initial grace period of 45 days to pay the first premium due, starting with the date COBRA coverage was elected.

If this first payment is not made when due, COBRA coverage will not take effect. After the first payment, subsequent payments are due on the first day of each month.

If you make a payment later than the first day of the coverage month to which it applies, but before the end of the grace period for that month, your benefits under the Plan will be suspended as of the first day of the coverage month and then retroactively reinstated (going back to the first day of the coverage

month) when the payment is received. This means that any Claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

- **If there is a significant payment shortage,** then COBRA Continuation Coverage will end as of the date for which the last full COBRA premium payment was made.
- **If there is not a significant payment shortage of your premium payment**, the Fund Office will notify you or the COBRA beneficiary of the deficient amount and allow a reasonable period of 30 days to pay the shortfall.
- The Trust Fund determines a significant payment shortage as the lesser of $50 or 10% of the required COBRA premium payment.
- If the shortage is paid in the 30-day time period COBRA Continuation Coverage will continue for the month in which the shortage occurred.
- If the shortage is not paid in the 30-day time period COBRA Continuation Coverage will end as of the date for which the last full COBRA premium payment was made and you will be refunded the amount paid that did not result in eligibility under the Plan.

Your Duty to Notify Fund Office

You or your Dependent is responsible for providing the Fund Office with notice of the Qualifying Event no later than 60 days following:

- The Retiree's death;
- a divorce of the Retiree and Spouse; or
- cessation of Dependent child's dependent status.

Failure to provide this notice within 60 days may prevent your Dependent(s) from obtaining or extending COBRA coverage.

Note: Failure to provide this notice within the time frames described below may prevent your Dependents from obtaining or extending COBRA coverage.

How to Notify the Fund Office

Notice of any Qualifying Event must be given to the Fund Office in writing. Written notice must contain the following information:

- Name of the qualified beneficiary;
- the Retiree's name and ID number or social security number;
- the event for which you are providing notice and the date of the Qualifying Event (for example, the date of a Dependent child's 26th birthday; and
- a copy of the final marital dissolution if the Qualifying Event is a divorce; or
- if you are a legal guardianship child of the Retiree or a child of the Domestic Partner of the Retiree and your status as a Dependent is based upon your full-time student status, and your Qualifying Event is a loss of status as an eligible Dependent, your letter should include the date you last attended school.

If you have any questions about how to notify the Fund of one of these events, please email the Fund Office at benefitservices@carpenterfunds.com or you may call (510) 633-0333 or (888) 547-2054.

Who Can Notify the Fund Office

Notice may be provided by the Retiree, the Dependent, or by any representative acting on behalf of the Dependent.

Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same Qualifying Event. For example, if a Spouse notifies the Fund Office of a Retiree's death, that single notice would satisfy the notification requirement for any eligible Dependent children.

Where to Send Your Notice

Notice of Qualifying Event must be provided to the Fund Office at the following address:

Carpenters Health and Welfare Trust Fund for California
265 Hegenberger Road, Suite 100
Oakland, California 94621-1480 Attention: Benefit Services

You can also e-mail your notice to benefitservices@carpenterfunds.com.

When to Notify the Fund Office

You must send the notice no later than **60 days after** the date of the Qualifying Event. Your Dependent's COBRA rights will be forfeited if you do not notify the Fund Office within this time frame.

Electing Continuation Coverage

After receiving notice of a Qualifying Event, the Fund Office will send you a notice of your right to choose Continuation Coverage with an election form, or, if you do not qualify for Continuation Coverage, a notice of unavailability of COBRA coverage. These notices will be sent within 60 days of the date the Fund Office receives notice of the Qualifying Event.

COBRA rights will be forfeited if you do not file the COBRA election form within this 60-day period.

You must sign and return the election form to the Fund Office no later than 60 days after the date of your loss of eligibility or the date the Fund Office provides the COBRA election notice (whichever is later) or you will forfeit your right to COBRA Continuation Coverage. If your Spouse and eligible Dependent children do not elect Continuation Coverage, coverage will end.

Initial Continuation Coverage will be identical to coverage provided to similarly situated Dependents under the Plan on the day prior to the Qualifying Event, although it may be modified if coverage changes for other Participants or Dependents.

Adding New Dependents

If, while your spouse is enrolled for COBRA Continuation Coverage, he or she has a newborn child, a child placed for adoption, or assumes legal guardianship of a child, that child may be enrolled for the balance of the period of your Spouse's Continuation Coverage, by sending a completed enrollment form to the Fund Office within 30 days after the birth, marriage or placement for adoption.

Special enrollment for the balance of your COBRA period is also allowed for Dependents who lose other coverage. For this to occur:

- Your Dependent must have been eligible for COBRA coverage on the date of the Qualifying Event but declined when enrollment was previously offered because he or she had coverage under another group health plan or had other health insurance coverage;

- your Dependent must exhaust the other coverage, lose eligibility for it, or lose employer contributions to it; and
- you must enroll that Dependent by sending an enrollment form to the Fund Office within 30 days after the termination of the other coverage or contributions.

Changing Medical Plans Under COBRA Continuation Coverage

If your Dependent(s) wishes to change medical plans while on COBRA, he or she must meet the same requirements as active Plan Participants. This means that he or she must be in a medical plan for at least 12 months before changing to a different medical plan. Exceptions are made only if the Dependent is enrolled in Kaiser and moves out of the Kaiser service area or a change is approved by the Board of Trustees.

If your Dependent is eligible for a change, he or she may submit a new enrollment form indicating the change to the Fund Office. Any change in plans will be effective on the later of the first day of the second calendar month following the date the enrollment form is received by the Fund, or the date Kaiser confirms enrollment in or disenrollment from Kaiser Senior Advantage.

Termination of COBRA Continuation Coverage

COBRA Continuation Coverage will terminate at the end of the maximum 36-month continuation period allowed. COBRA Continuation Coverage will terminate earlier, before the end of the 36-month period, upon the occurrence of any of the following events:

1. Your Dependent fails to remit the required premium payments in full and on time (within 45 days following the submission of the initial COBRA election form and including the cost of coverage retroactive to the first day your coverage would have otherwise terminated, or within 30 days following the due date for subsequent monthly payments).
2. Your Dependent becomes covered under any other group medical plan after the date you elect COBRA coverage.
3. Your Dependent(s) becomes entitled to Medicare after the date of your COBRA election (entitled to Medicare means being enrolled in either Part A or Part B of Medicare, whichever occurs earlier).
4. The Trust Fund ceases to provide group health coverage to any Participants.

COBRA Continuation Coverage will terminate on the **first day of the month** following events 1 through 4 above.

If COBRA coverage is terminated before the end of the maximum period of coverage, the Fund Office will send you a written notice as soon as practicable following its determination that Continuation Coverage will terminate.

Keeping the Fund Office Notified

If you have changed marital status, or you have changed your address, please contact the Fund Office.

Note: Should Federal or State law change the provisions of COBRA in existence at the time this Summary Plan Description is printed or if there is a change to the Plan, the Trust Fund will advise you of these changes.

COBRA Continuation Coverage – Quick Reference Chart

Qualifying Event	Qualified Beneficiary	Maximum Continuation Period
A Retiree's death	Your Spouse and Dependent children	36 months after date of Qualifying Event
Your divorce	Your former Spouse and Dependent children	36 months after date of Qualifying Event
Cessation of Dependent status under Plan	Affected child if covered under Plan	36 months after date of Qualifying Event

Other Health Coverage Alternatives to COBRA (For People Who Are Not Eligible for Medicare)

You may have other health coverage alternatives to COBRA available to you that can be purchased through the **Health Insurance Marketplace** (*the Marketplace helps people without health coverage find and enroll in a health plan. For California residents see: www.coveredca.com. For non-California residents see your state Health Insurance Marketplace or www.healthcare.gov*).

You could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for a tax credit. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a Spouse's plan), if you request enrollment in that other plan within 30 days of losing coverage under this Plan, even if that other plan generally does not accept late enrollees.

Conversion to Kaiser Individual Coverage

If your Dependent(s) are enrolled in Kaiser when your COBRA Continuation Coverage ends, he or she may enroll in any individual conversion plan offered by Kaiser at the end of the Continuation Coverage period, as described in their Evidence of Coverage brochure.

This option applies only to Kaiser members.

Check your Kaiser Evidence of Coverage brochure for more information on how to enroll in a conversion plan. You can also call Kaiser's member services department.

Note: Your Dependent(s) may also have the option to purchase individual Conversion Coverage from Kaiser instead of COBRA coverage, but only if he or she was enrolled in Kaiser when your Trust Fund coverage ended.

Continuation of Coverage for Domestic Partners and Children of Domestic Partners

Eligible Domestic Partners of a Retiree and eligible children of Domestic Partners who lose eligibility under the Plan may continue Plan coverage through self-payment for a limited period of time. The Domestic Partner and children of the Domestic Partner who lose eligibility under the Plan may continue Plan coverage when eligibility is lost due to any of the following reasons:

- The Retiree's death;
- termination of Domestic Partner relationship with the Retiree; or
- cessation of child's Dependent status under the Plan.
- Coverage may be continued for up to 36 months from the date of the event that resulted in loss of eligibility.
- Continuation Coverage will be terminated before the end of the 36-month period upon the occurrence of any of the following events:
- The required premium payment for Continuation Coverage is not paid when due;
- the Trust Fund ceases to provide group health coverage to any participants;
- the Domestic Partner or Dependent child becomes covered under any other Group Plan (as a Participant or otherwise);
- any Domestic Partner becomes entitled to Medicare coverage.

Premiums

A premium for Continuation Coverage will be charged to the Domestic Partner or Dependent child, or both, in amounts established by the Board of Trustees. The premium is payable in monthly installments.

Election and Notice Procedure for Domestic Partner Continuation Coverage

The Domestic Partner or child of the Domestic Partner, or both, must elect Continuation Coverage within 60 days after the later of:

- The date of any of the events described above under "COBRA Continuation of Coverage Under Federal Law"; or
- The date the Fund Office provides notice the individual of his or her right to Continuation Coverage.

Kaiser HMO

If you are enrolled with the Kaiser Permanente HMO Plan, you will be eligible for medical, prescription Drug, hearing aid and vision benefits.

If you would like a copy of your Kaiser Evidence of Coverage (EOC), please contact Kaiser Member Services at (800) 464-4000 or visit the Fund Office website, www.carpenterfunds.com.

Patient Protection Rights

PCP Designation

Kaiser generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser member services at (800) 464-4000.

For children, you may designate a pediatrician (including pediatric subspecialties) as primary care provider, if that provider is accepting patients.

Access to Ob/Gyn Provider

You do not need prior authorization from Kaiser or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Kaiser at (800) 464-4000.

Non-Discrimination in Health Care

In accordance with the Affordable Care Act, to the extent an item or service is a covered benefit under the Plan, and consistent with reasonable medical management techniques with respect to the frequency, method, treatment or setting for an item or service, Kaiser will not discriminate with respect to participation under the Plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable state law. In this context, discrimination means treating a provider differently based solely on the type of the provider's license or certification. Kaiser is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by Kaiser. The HMO is permitted to establish varying reimbursement rates based on quality or performance measures.

Section 2 - Indemnity Medical Plan For Retirees Without Medicare

This section includes:

- An overview of how the Plan works, including rules, maximum Allowable Charges, and Utilization Review guidelines;
- tips and resources to make the most of your benefits;
- a detailed schedule of benefits including medical, prescription Drugs and vision.

Please Note

The benefits in this chapter do not apply to Retirees or Dependents who are eligible for Medicare or who are enrolled in the Kaiser HMO plan. If you and your eligible Dependents are covered under the Kaiser HMO plan, please contact Kaiser (at the telephone number on the Quick Reference Chart) for a copy of your Evidence of Coverage (EOC) that outlines your medical benefits under the Kaiser HMO plan.

Indemnity Plan Overview

The Indemnity Medical Plan provides benefits to help cover the cost for a wide range of Medically Necessary services and supplies, including Hospital and Physician charges, diagnostic testing and surgery, as well as some preventive health care benefits specifically listed as covered by the Plan.

Plan Participants may obtain health care services from Contract or Non-Contract providers. The amount that you pay for such services may be higher if performed by Non-Contract Providers.

Benefits will be paid only for expenses you and your eligible Dependents incur while you are eligible under the Plan (except for the extended benefits provision in Section 3.09) and COBRA Continuation Coverage for Dependents.

How the Plan Works

Each year, you must pay a certain amount in Covered Expenses before the Plan starts paying benefits. This is called your Deductible. Once you have met the Deductible, the Plan pays a percentage of the Covered Expenses. The percentage paid by the Plan is higher if you use Contract Providers. You pay the remaining percentage (called your Coinsurance) plus any expenses that are not covered.

Your Plan has a yearly maximum out-of-pocket amount. This means, there is a limit to the total amount you will have to pay for medical services from Contract Providers. Once your out-of-pocket expenses for Covered Expenses reach a certain level for the year, the amount paid by the Plan increases to 100% of Covered Expenses for the rest of the year if you use Contract Providers and with certain exceptions. These Plan features and others are discussed in more detail in this Summary Plan Description.

Covered Services

The Plan will pay benefits for the preventive services specifically listed as covered by the Plan and for Medically Necessary services, supplies, care and treatment that are prescribed, performed or ordered by a Physician for treatment of an Illness or Injury. In addition to information noted in "Indemnity Medical Plan Exclusions," the Plan will not pay benefits for any expenses related to an occupational Injury or Illness. A list of covered services can be found on the chart labeled **Schedule of Indemnity Medical Plan Benefits for Retirees Without Medicare**, beginning on page 54.

Deductibles

Generally, the Plan will not reimburse you for all services. Usually, you will have to satisfy a Deductible and pay some Coinsurance toward the amounts you incur that are Allowed Charges. However, once you have incurred your Coinsurance Maximum limits each calendar year, no further Coinsurance will be applied for that calendar year for Contract Provider services.

The annual Deductible is the amount you must pay toward eligible expenses each calendar year before the Plan begins to pay benefits. Each calendar year, you (and **not** the Plan) are responsible for paying all of your Covered Expenses until you satisfy the annual Deductible. Once the Deductible has been satisfied the Plan will begin to pay benefits towards Covered Expenses. There are two types of annual Deductibles: Individual and family.

- The **individual Deductible** is the amount one covered person has to pay each year towards Covered Expenses before Plan benefits begin.

- The **family Deductible** is the total amount that a family of two or more persons is responsible for paying each year towards Covered Expenses before Plan benefits begin. Only expenses that have actually been applied to family members' per person deductible will count towards the family Deductible. Once the family Deductible is met, the individual Deductible no longer applies.
- ***Contract Providers*** - $128 per person, not to exceed $256 per family
- ***Non-Contract Providers*** - $257 per person, not to exceed $514 per family

The Deductible does not apply to prescription Drug benefits, women's preventive care services, certain vaccines and immunizations, Live Health On-Line physician visits and certain other expenses as outlined in the Schedule of Medical benefits.

Coinsurance

Coinsurance refers to how you and the Plan will split the cost of certain covered medical expenses. Once you've met your annual Deductible, the Plan generally pays a percentage of the Covered Expenses, and you (and **not** the Plan) are responsible for paying the rest. The part you pay is called Coinsurance.

In general, the Plan pays 90% of the negotiated contract rate to Contract Providers and the Plan pays 70% of the Plan's Allowed Charges to Non-Contract Providers. Your Plan pays a higher benefit and your cost is lower if you use Contract Providers.

Coinsurance Maximum

Each Calendar Year, after an individual or family has incurred a Coinsurance Maximum for Contract Provider expenses over $1,289 per individual or $2,578 per family, no further Coinsurance will apply to Covered Expenses by Contract Providers. As a result, the Plan will pay 100% of Covered Expenses during the remainder of the calendar year **except for** expenses that do not apply toward your Coinsurance Maximum as listed below. For expenses incurred by Non-Contract Providers, you will have no Coinsurance Maximum.

Once you or your family have incurred your Coinsurance Maximum, the Plan will pay 100% of Covered Expenses during the remainder of the calendar year **except for**:

- Expenses that do not apply toward your Coinsurance Maximum

Expenses That Do Not Accumulate to Your Coinsurance Maximum

This Plan rarely pays benefits equal to **all** the medical expenses you may incur. You are often responsible for paying for certain expenses for medical services and supplies yourself. Under the Plan, each year, you will be responsible for paying the following expenses out of your own pocket **and** these expenses do not accumulate to meet your Coinsurance Maximum:

- Premiums
- Balance-billed charges
- Plan Deductibles
- All expenses for medical services or supplies that are not covered by the Plan
- All charges in excess of the Allowed Charge determined by the Plan
- All charges in excess of the Plan's maximum benefits, or in excess of any other limitation of the Plan
- Any additional amounts you have to pay because you failed to comply with the Utilization Review requirements of the Plan

- Prescription Drugs (including any Copayment and/or Coinsurance amounts)
- Expenses incurred by Non-Contract Providers

Preferred Provider Organization (PPO)

The Plan's Preferred Provider Organization (PPO) is a network of Contract Hospitals, Physicians, laboratories and other Providers who are located within a service area and who have agreed to provide health care services and supplies for favorable negotiated discount fees applicable only to PPO Plan Participants. All Providers who are part of the PPO are considered Contract Providers. If you receive Medically Necessary services or supplies from a Contract Provider, you will pay a smaller Deductible and lower Coinsurance than if you received those Medically Necessary services or supplies from a provider who is not a Contract Provider. Also, the Contract Provider has agreed to accept the Plan's payment plus any applicable Coinsurance that you are responsible for paying as payment in full.

Directories of Contract Providers

A directory of Contract health care Providers is available on the internet at www.anthem.com. Please contact the Fund Office if you would like a free Provider directory sent to you.

If you obtain and rely upon incorrect information about whether a provider is a Contract provider from the Plan or its administrators, the Plan will apply contract Cost-Sharing to your Claim, even if the provider was not a Contract Provider.

Continuity of Coverage

If you are a Continuing Care Patient (as defined below), and Anthem terminates its contract with your provider or facility, Anthem will do the following:

- Notify you in a timely manner of the Plan's termination of its contract with the provider or facility and inform you of your right to elect continued transitional care from the provider or facility; and
- Allow you ninety (90) days of continued coverage at cost sharing at negotiated fees to allow for a transition of your care to a Contract Provider.
- Continuing Care Patient means an individual who, with respect to a provider or facility:
- Is undergoing a course of treatment for a serious and complex condition from the provider or facility;
- is undergoing a course of institutional or inpatient care from the provider or facility;
- is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

Because providers are added to and dropped from the PPO network periodically throughout the year it is best if you ask your provider if they are a Contracted Provider or contact the PPO network before you seek services when possible.

For a list of Contract providers go to www.anthem.com or contact the Fund Office.

Contract and Non-Contract Providers

Contract Providers

If you receive medical services or supplies from a Provider that is contracted with the Plan's medical network, you will be responsible for paying less money out of your pocket. Providers who are under a contract with the network have agreed to accept the discounted amount the Plan pays for covered services. You will be required to pay the applicable Deductibles and Coinsurance remaining after Plan benefits are paid, up to the discounted amount.

Value-Based Facilities for Inpatient Hip or Knee Replacement

In-patient Hospital Plan benefits will be limited to $35,000 for single hip joint replacement or single knee joint replacement surgery. The maximum applies to all Hospital facility costs but does not include professional fees such as anesthesia or surgical fees. There are specific value-based PPO hospitals throughout California where these surgeries can be performed which will minimize your out-of-pocket costs beyond the Plan's deductible and coinsurance. If you require hip or knee replacement surgery, visit the Fund Office website at www.carpenterfunds.com or call the Fund Office at (888) 547-2054 for the list of Hospitals which can provide services at a lower cost.

Non-Contract Providers

Non-Contract Providers refers to providers who are not contracted with the medical Plan's PPO network and who do not generally offer any fee discount to the Participant or to the Plan. These Non-Contract providers **may bill a Plan Participant a non-discounted amount** for any balance that may be due in excess of the Plan's Allowed Charge.

Limited benefits will be paid for services obtained by a Non-Contract provider who did not complete enrollment in the Medicare program. See the **Schedule of Indemnity Plan Medical Plan Benefits for Retirees Without Medicare** beginning on page 54 for more information. To avoid unforeseen costs before receiving services from a Non-Contract Provider, confirm that the Provider has registered for Medicare, even if you are not Medicare eligible.

Emergency Care with Non-Contract Providers

Your Cost-Sharing amount for Emergency Services at Contract Facilities by Non-Contract Providers will be based on the Recognized Amount, which is, generally, the lesser of the billed charges from the Non-Contract Provider or the Qualifying Payment Amount (i.e., the Plan's median of contracted rates for the item or service in that location).

Emergency Services are covered:

- Without the need for a prior authorization determination, even if the services are provided by Non-Contract providers;
- without regard to whether the health care provider furnishing the Emergency Services is a Contract Provider or a Contract Emergency Facility, as applicable, with respect to the services;
- without imposing any administrative requirement or limitation on Non-Contract Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from Contract Providers and Contract Emergency Facilities;

- by calculating the Cost-Sharing requirement for Non-Contract Emergency Services as if the total amount that would have been charged for the services were equal to the recognized amount for the services; and
- by counting any Cost-Sharing payments made by the Participant or beneficiary with respect to the Emergency Services performed by a Non-Contract Provider toward any contracting Deductible or contracting out-of-pocket maximums applied under the Plan in the same manner as if the Cost-Sharing payments were made with respect to Emergency Services were furnished by a Contracting provider or a Contracting Emergency facility.

In general, you cannot be balance billed for these Emergency Services. The Cost-Sharing amount for Emergency Services from Non-Contracting Providers will be based on the lesser of billed charges from the provider or the Qualified Payment Amount (QPA).

Non-Emergency Care with Non-Contract Providers at a Contract Facility

With regard to non-Emergency items or services that are otherwise covered by the Plan, if the services are performed by a Non-Contracting Provider at a Contract Health Care Facility, the items or services are covered by the Plan:

- With a Cost-Sharing requirement that is no greater than the Cost-Sharing requirement that would apply if the items or services had been furnished by a Contract Provider;
- by calculating the Cost-Sharing requirements as if the total amount that would have been charged for the items and services by such participating Provider were equal to the recognized amount for the items and services;
- by counting any Cost-Sharing payments made by the Patient toward any contract Deductible and contract Coinsurance Maximums applied under the Plan.
- In general, you cannot be balance billed for these items or services.
- Services will be covered based on the Plan's definition of Allowed Charge and forgo the financial protections outlined above if:
- At least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), the Patient is supplied with a written notice that the provider is a Non-Contract Provider, an estimate of the charges for treatment and any advance limitations that the Plan may put on the treatment, the names of any Contract Providers at the facility who are able to treat the Patient, and that the Patient may elect to be referred to one of the Contract Providers listed; and
- the Patient gives informed consent to continued treatment by the Non-Contract Provider, acknowledging that they understand that continued treatment by the Non-Contract Provider may result in a greater out-of-pocket cost.

The notice and consent exception for non-Emergency items or services provided by a Non-Contract Provider at a Contract Health Care Facility does not apply to Ancillary Services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Non-Contract Provider satisfied the notice and consent criteria.

The Cost-Sharing amount for non-Emergency Services at Contract Facilities by Non-Contract Providers will be based on the Recognized Amount, which is, generally, the lesser of the billed charges from the Non-Contract Provider or the Qualifying Payment Amount (i.e., the Plan's median of contracted rates for the item or service in that location).

Air Ambulance Services

If you receive air ambulance services that are otherwise covered by the Plan from a Non-Contract Provider, those services will be covered by the Plan as follows:

- The air ambulance services received from a Non-Contract Provider will be covered with a Cost-Sharing requirement that is no greater than if the services had been furnished by a Contract Provider.
- Your Cost-Sharing will be calculated as if the total amount that would have been charged for the services by a Contract Provider of Air Ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services.
- Any Cost-Sharing payments you make with respect to covered air ambulance services will count toward your contract Deductible and contract Coinsurance Maximum.

In general, you cannot be balance billed for these items or services.

To Avoid a Reduction in Benefits

- Use the Plan's Contract Hospitals when you or your eligible Dependents require hospitalization.
- Get Utilization Review for inpatient Hospital stays. If you use a Contract Hospital, the Hospital will take care of the Utilization Review for you. If you use a Non-Contract Hospital, it is your responsibility to make sure Anthem Blue Cross has pre-approved the hospital confinement or your benefits may not be payable.
- Use Contract Physicians, Hospitals, laboratory and radiology facilities, value-based services and other Contract Providers such as surgical centers and urgent care facilities. By using Contract Providers, you will receive the maximum benefits payable and save yourself and the Plan money.

Maximum Allowable Charges Apply for Certain Surgical Procedures

Ambulatory surgical centers can provide high quality care and are often the most cost effective choice for a variety of surgical procedures. For certain procedures, listed below, the Fund will limit the maximum allowable charge if you choose to go to a Hospital instead of an ambulatory surgical center. If you receive care at an ambulatory surgical facility, the maximum allowable charge will be determined based on whether you receive services at a Contract or Non-Contract Facility.

The Fund will limit benefit payments for the following surgical procedures if performed at a Hospital. The maximum payment is the highest amount your Plan will pay for these procedures. Any amount over the maximum will be your responsibility to pay. These limitations do not apply if you receive services at a contract ambulatory surgical center.

Procedure	Maximum Payment to the Hospital*
At a Hospital (whether inpatient or outpatient)	
Routine Total Hip Replacement Surgery	$35,000

Procedure	Maximum Payment to the Hospital*
Routine Total Knee Replacement Surgery	$35,000
At an Outpatient Hospital (instead of an ambulatory surgical center)	
Arthroscopy	$6,000
Cataract Surgery	$2,000
Colonoscopy	$1,500
All other Endoscopies	$1,000
Laparoscopic gall bladder - removal	$5,000
Hysteroscopy uterine tissue sample (with biopsy, with or without dilation and curettage)	$3,500
Nasal/Sinus - submucous resection inferior turbinate services	$3,000
Tonsillectomy and/or adenoidectomy (for a Member under age 12)	$3,000
Nasal/sinus - corrective surgery - septoplasty	$3,500
Lithotripsy	$7,000
Hernia inguinal repair (over age 5, non-laparoscopic)	$4,000
Esophagoscopy	$2,000
Repair of laparoscopic inguinal hernia	$5,500
Sigmoidoscopy	$1,000
Upper gastrointestinal endoscopy without biopsy	$1,500
Upper gastrointestinal endoscopy with biopsy	$2,000

**Please note: Amounts denied as over the maximum benefit payment for a procedure will not accumulate toward your Coinsurance Maximum.*

Exceptions Process

We realize there are certain times you may not be able to use a Provider, Hospital, or outpatient surgery center who has agreed to accept the maximum allowable charge. Therefore, in the following situations, the Fund may make an exception for you:

- If your access to a Provider, Hospital, or outpatient surgery center that will accept the maximum allowable charge is unavailable or the service cannot be obtained within a reasonable wait time or travel distance; and
- if the quality of services for you or your Dependent(s) could be compromised by receiving services from a Contract Provider, Hospital, or outpatient surgery center (e.g., if comorbidities present complications or Patient safety issues).

Information about the Maximum Allowable Charge

Upon request, the Fund Office will provide you with a list of Hospitals that will minimize your out-of-pocket amount related to knee and hip replacement surgery.

The Plan works together with Anthem Blue Cross to ensure there are an adequate number of Providers, Hospitals and out-patient surgery centers that meet quality standards.

Exceptions to Non-Contract Provider Deductible and Benefit Payment

The following chart explains the Plan's special reimbursement for services when certain Non-Contract Providers are used. The Plan Trustees or its designee determine if and when the following special reimbursement circumstances apply to a Claim after the normal Claim adjudication processes have been followed/investigated.

Special Reimbursement Provisions	**What the Plan Pays** (toward eligible Claims submitted by a Non- Contract Provider)
• If a Non-Contract anesthesiologist or Emergency room Physician provides services at a Contract Hospital or Facility • Licensed ambulance service (including air ambulance) provided by a Non-Contract Provider • Emergency Services provided by a Non-Contract Provider at a Contract Facility (regardless of the department of the facility in which the items or services are furnished) until the provider or facility determines that the Participant or Dependent is able to travel using nonmedical transportation or Non-Emergency medical transportation to a different Contract Facility. In this case, Emergency Services include post stabilization services and services provided as part of outpatient observation or an inpatient or outpatient stay related to an Emergency medical condition • If the patient remains in a Non-Contract Hospital after the acute Emergency period, the Non-Contract Provider Deductible and payment percentage will apply for the period of confinement after the Emergency period has ended • If the service(s) provided is Medically Necessary and not available from a Contract Provider	As if the care was provided by a Contract Provider including Deductible, Coinsurance and Coinsurance Maximum. Bills will be reimbursed according to the Allowed Charge.

Women's Health and Cancer Rights Act of 1998

All plans that cover mastectomies are also required to cover related reconstructive surgery. For any eligible individual receiving benefits for a mastectomy, coverage will be provided in a manner determined in consultation with the attending Physician and the Patient for both reconstruction of the breast on which the mastectomy was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance. Coverage is also available for breast prostheses and for treatment of physical complications of mastectomy, including lymphedemas.

Newborns' and Mothers Health Protection Act of 1996

Group health plans and health insurance issuers offering group health coverage generally 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 delivery or less than 96 hours following a cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending Physician, after consultation with the mother, discharges the mother or newborn earlier. Also under Federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. Plans and issuers may not, under Federal law, require that a health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

Utilization Review Program

Purpose of the Utilization Review Program

The Plan's Utilization Review Program is designed to help control increasing health care costs by avoiding unnecessary services or identifying services that can be provided in a more cost-effective manner to achieve the same result. By doing this, the Fund is better able to afford to maintain the Plan and all its benefits. If you follow the procedures of the Plan's Utilization Review Program, you may avoid some out-of-pocket costs. However, if you don't follow these procedures, you may be responsible for paying more out of your own pocket.

Management of the Utilization Review Program

The Plan's Utilization Review Program is administered by Anthem. In addition, certain outpatient Drugs may require Utilization Review as managed by the pharmacy benefit manager, Express Scripts.

Elements of the Utilization Review Program

The Plan's Utilization Review Program consists of:

- **Pre-authorization (pre-service) review**: Review of proposed health care services before the services are provided.
- **Concurrent (continued stay) review**: Ongoing assessment of health care as it is being provided, typically involving inpatient confinement in a Hospital or health care facility or review of the continued duration of healthcare services.
- **Retrospective review**: Review of health care services **after** they have been provided.

Restrictions and Limitations of the Utilization Review Program

The fact that your Physician recommends a surgery, hospitalization, or that your Physician proposes or provides medical services or supplies doesn't mean that the services or supplies will be an Allowed Charge or be considered Medically Necessary for determining coverage under the Indemnity Medical Plan.

All treatment decisions rest with you and your Physician. You should follow whatever course of treatment you and your Physician (or other Provider) believes to be the most appropriate, even if Anthem does not certify proposed surgery/treatment/service or admission as Medically Necessary.

Precertification of a service does not guarantee that the Plan will pay benefits for that service because other factors may disqualify a service from payment. Examples of these factors include but are not limited to:

- Ineligibility for coverage on the actual date of service;
- the information submitted during precertification varies from the actual services performed on the date of service; and/or
- the service performed is not a covered benefit.

How Utilization Review Works

Utilization Review is a procedure administered by Anthem, to assure that health care services meet or exceed accepted standards of care and that the admission and length of stay in a Hospital or health care facility, or a surgery or other health care services are Medically Necessary.

THE FOLLOWING SERVICES MUST BE APPROVED BY ANTHEM IN ADVANCE OF THE PROCEDURE:

Situation	Plan Requirements For Utilization Review
Non-Emergency admission to a Hospital including mental illness or chemical dependency treatment (excluding childbirth)	If you use a Contract Hospital, the Hospital will handle this for you. If you use a Non-Contract Hospital, you are responsible for seeing that your Physician obtains Utilization Review for you. You are not required to obtain Utilization Review for a hospitalization when the Plan is the secondary payer of benefits.
Hospitalization as a result of a medical Emergency	If you are admitted to a Non-Contract Hospital, you, your Physician or someone acting on your behalf must contact Anthem for certification within 24 hours of admission.
Admission for childbirth	You do not need Utilization Review for mother and newborn Hospital stays of less than 48 hours following a normal delivery or a stay of less than 96 hours following a cesarean section.
Organ or tissue transplant	All planned services must be approved by Anthem before services begin.
Certain outpatient diagnostic imaging services	CT/CTA, MR/MRI, nuclear cardiology, PET scan and echocardiography before the service is provided.
Certain outpatient surgeries	Colonoscopy, Arthroscopy, Cataract Surgery, All other Endoscopies, Laparoscopic gall bladder – removal, Hysteroscopy uterine tissue sample (with biopsy, with or without dilation and curettage), Nasal/Sinus - submucous resection inferior turbinate services, Tonsillectomy and/or adenoidectomy (for a Member under age 12), Nasal/sinus - corrective surgery – septoplasty, Lithotripsy, Hernia inguinal repair (over age 5, non-laparoscopic), Esophagoscopy, Repair of laparoscopic inguinal hernia, Sigmoidoscopy, Upper gastrointestinal endoscopy without biopsy, Upper gastrointestinal endoscopy with biopsy, Single knee replacement, and Single hip replacement must be approved by Anthem before the service is provided.
Certain Specialty drugs	The following Specialty Drugs may be covered under either the Indemnity Medical Plan benefit or the prescription Drug benefit. If filled under the medical Plan benefit, they must be approved by Anthem before the Drug is provided. • Zirabev or generic Mvasi bevacizumab • Uplizno (or generic ipilimumab) • Keytruda (or generic pembrolizumab) • Herceptin (or generic trastuzumab) • Rituxan (or generic rituximab) • Prolia (or generic Xgeva denosumab) • Opdivo (or generic nivolumab) • Lupron (or generic leuprorelin)

RECEIVING UTILIZATION REVIEW DOES NOT MEAN BENEFITS ARE PAYABLE IN ALL CASES

Coverage depends on the services that are actually provided, your eligibility status at the time service is provided, and any benefit limitations.

Anthem will determine whether a proposed admission to the Hospital is Medically Necessary and if so, how many days will be covered. Anthem and the Physician will review the facts about a Patient's case to determine if hospitalization is necessary or if effective treatment can be given in a less intensive setting such as outpatient care. Once you are admitted, Anthem monitors the Hospital stay and if additional days are required because of complications or other medical reasons, your stay will be approved for the appropriate number of additional inpatient days. This is called Concurrent Review.

A Contract Hospital will take care of the Utilization Review process for you (including concurrent review).

If you are admitted to a Non-Contract Hospital, it will be your responsibility to make sure your Physician contacts Anthem for Utilization Review. For Emergency admission, Anthem must be notified within 24 hours after you are admitted. Anthem will determine the number of days of confinement that are Medically Necessary.

If you are admitted to a Non-Contract Hospital that does not participate in a concurrent review program, your Hospital stay will be reviewed after you leave the Hospital. If Anthem finds that any portion of your stay was not Medically Necessary, no benefits will be payable for Hospital and Physician charges incurred during the portion of the Hospital stay that was determined to be not Medically Necessary.

Benefits will be paid for an organ or tissue transplant **only** if the medical services are approved in advance and managed by Anthem.

Failure to comply with the Plan's requirements for Utilization Review and notification of an Emergency admission may result in services not being covered.

EMERGENCY HOSPITALIZATION

If an Emergency requires hospitalization, there may be no time to contact Anthem before you are admitted. If this happens, Anthem must be notified of the Hospital admission within 24 hours. You, your Physician, the Hospital, a family member or friend can make that phone call to Anthem. This will enable Anthem to assist you with your discharge plans, determine the need for continued medical services, and/or advise your Physician or other providers of the various contracted support providers and benefits available for you and offer recommendations, options and alternatives for your continued medical care.

If Anthem is not contacted within 24 hours of your hospitalization, a retroactive review of the hospitalization will determine if the Claim satisfies the criteria for Medical Necessity. If denied, you may be liable for expenses.

Retrospective (Post-Service) Review

Claims for medical services or supplies that have not been reviewed under the Plan's Utilization Review program including pre-authorization and concurrent (continued stay) review may, at the option of the Fund Office, be subject to retrospective review to determine if they are Medically Necessary. If the Fund Office receives a determination from Anthem that services or supplies were not Medically Necessary, **no benefits will be provided by the Plan for those services or supplies.**

Appealing a Utilization Review Determination (Appeals Process)

You may request an appeal of any adverse review decision made during the Utilization Review process described in this chapter. To appeal a denied Claim/bill, see the **Claims and Appeals Procedures** chapter beginning on page 96 of this document.

Time Limit for Initial Filing of Health Claims

You must submit all health care Claims within 90 days of when expenses are incurred unless it is not reasonably possible to do so. In no event will Claims be paid if they are submitted more than 1 year after the date the expenses were incurred. The Claim must be complete and be an itemized bill or bills. You may be asked to submit supporting documentation for the Claim submitted.

See also the **Claims and Appeals Procedures** chapter for more information beginning on page 94. Also review the section toward the end of that chapter on "**If Your Appeal is Denied**" (on page 100).

Making the Most of your Benefit – Tips and Resources

Here are a few tips to make your experiences both successful and affordable using the Indemnity Medical Plan:

General

- No matter what kind of treatment you are seeking, always confirm whether providers are PPO Contract Providers to receive the highest level of benefit possible under the Plan. You can locate a Contract Provider or determine if your current provider is a Contract Provider by visiting Anthem's website, www.anthem.com. Click on "Find Care" and select your state and location and the type of provider you are seeking; or type in your current provider's name to verify their participation in the network. You can also contact the Fund Office for assistance. Email the Fund Office at benefitservices@carpenterfunds.com or call (888) 547-2054.
- Use the Advisor service to help avoid paying unnecessary personal medical bills and reduce your personal costs. For Advisor assistance, call (844) 437-0488.
- Register at www.anthem.com with a username and password. When you login, you can use the Anthem Care Comparison tool to research the cost and quality of procedures performed by facilities near you. For example, a colonoscopy can cost anywhere from $450 to $3,000; or one provider may have more experience performing that procedure than another provider.
- While you are logged in to www.anthem.com, you can look for special offers that may help your recovery or overall wellness such as weight loss programs, hearing aids or gym memberships.
- If your doctor ever recommends care for you that requires the services of several different providers, or if your doctor recommends you receive services from another provider altogether, be sure to ask whether the new provider is in the PPO network.

Surgery

- When you make an appointment to see a surgeon, ask if the doctor participates in the Anthem PPO network.
- Before you have surgery, find out from the surgeon if an assistant surgeon, anesthesiologist physician or a certified registered nurse anesthetist will be involved. If an assistant surgeon will be involved, call the Fund Office. The Fund Office can check to see if the assistant surgeon's involvement is necessary and inform you of any additional out-of-pocket expenses you may incur if the provider's billed charges exceed the Plan's allowance.
- Using a contract ambulatory surgery center for these surgeries can greatly reduce your out-of-pocket expense. Some surgeries such as colonoscopy, arthroscopy, endoscopy, cataract surgery, laparoscopic gall bladder removal, hysteroscopy uterine tissue sample (with biopsy, with or without dilation and curettage), nasal/sinus - submucous resection inferior turbinate services, tonsillectomy and/or adenoidectomy (for a Member under age 12), nasal/sinus - corrective surgery – septoplasty, lithotripsy, hernia inguinal repair (over age 5, non-laparoscopic), esophagoscopy, repair of laparoscopic inguinal hernia, sigmoidoscopy, upper gastrointestinal endoscopy without biopsy, upper gastrointestinal endoscopy with biopsy, single knee replacement and single hip replacement have specific dollar limits if you use an outpatient Hospital (defined as a Hospital where you receive care without being admitted or for a stay of less than 24 hours) instead of an ambulatory surgery center.

- There are specific Plan maximum benefits for Hospital charges if you have a regular total knee or hip replacement surgery. To reduce your out-of-pocket expense for an inpatient knee or hip replacement surgery use one of the specific value-based Hospitals for services. You can view the list of value-based Hospitals on the Fund Office website: www.carpenterfunds.com.

Laboratory and Pathology Tests

- When you need laboratory or pathology tests performed, ask your doctor if you can use an independent contract laboratory for services. Services at these independent labs can cost 70%-75% less than the same services provided by Hospital-based facilities and non-network laboratories.
- For help finding the nearest contract laboratory, visit www.anthem.com. You may contact the Fund Office for a list, free of charge.
- Here are some additional resources available to Indemnity Plan Participants:

LiveHealth Online

When you use this service, you can talk to a doctor any time of day, on your computer or mobile device using two-way video or audio chat, without an appointment. The Fund will reimburse any charge for this service at 100%. You can access LiveHealth Online either by going to the website: www.livehealthonline.com from a computer with a webcam and internet access or by downloading the LiveHealth Online mobile app to your iOS or Android smartphone or tablet.

Nurse Line

The Plan offers a no-cost nurse advice helpline to help you decide if your symptoms can be treated with a home remedy, if you need to make a doctor's appointment or if urgent care is needed. You can contact the nurse line by calling (800) 700-9184 any time day or night. However, if you have an Emergency, call 911 for help.

Cancer Navigator

CancerNavigator is a no-cost benefit offered to all Participants on the Carpenters Indemnity Plan. *(Note – not intended for Participants on the Kaiser HMO plan.)* The CancerNavigator service provides tailored education and guidance to cancer patients as they navigate the many decisions that follow a diagnosis.

Support for cancer patients includes:

- Access great centers quickly
- Learn which centers in your area are well-equipped to treat your specific cancer type
- Understand your specific diagnosis and treatment options
- Talk through any questions you may have about your clinical situation
- Schedule appointments with the best centers in your area

Schedule of Indemnity Medical Plan Benefits for Retirees Without Medicare

Please Note

The benefits in the Schedule of Benefits do not apply to Medicare eligible Retirees or Kaiser HMO plan Participants. If you and your eligible Dependents are covered under the Kaiser HMO plan, please contact Kaiser at (800) 464-4000 or go to carpenterfunds.com for a copy of your Evidence of Coverage (EOC) that outlines your medical benefits under the Kaiser HMO plan.

A **Schedule of Non-Medicare Eligible Indemnity Medical Plan Benefits** appears beginning on the following page in a chart format. Each of the Plan's medical benefits is described in the first column. Explanations and limitations that apply to each of the benefits are shown in the second column. Specific differences in the benefits when they are provided by Contract Providers and Non-Contract Providers are shown in subsequent columns.

Deductibles, Coinsurance Maximums, Hospital services (inpatient) and Physician and other health care services are listed first because these categories of benefits apply to most (but not all) health care services covered by the Plan. Unless there is a specific statement in the **Schedule of Non-Medicare Eligible Indemnity Medical Plan Benefits**, all benefits shown are subject to the Plan's Deductibles.

Schedule of Non-Medicare Eligible Indemnity Medical Plan Benefits

All benefits are subject to Deductible except where noted

***Important:** Non-Contract Providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.

Benefit Description	Explanations and Limitations	Benefits for Non-Medicare Eligible Retirees and Dependents Contract Providers	Benefits for Non-Medicare Eligible Retirees and Dependents Non-Contract Providers
Deductible (See Section 3.01 of the Rules and Regulations) The annual Deductible is the amount of money you must pay each calendar year before the Plan begins to pay benefits for most services. • Deductibles are applied to Covered Expenses in the order in which Claims are processed by the Plan. • Only Covered Expenses can be used to satisfy the Plan's Deductibles. • The Deductible applies to all covered services except where otherwise noted in this **Schedule of Indemnity Medical Plan Benefits**. • The family Deductible is the total amount that a family of two or more persons is responsible for paying each year towards Covered Expenses before Plan benefits begin. Only expenses that have actually been applied to a family member's per person Deductible will count towards the family Deductible.	• Amounts cross-accumulate between Contract and Non-Contract Providers– for example, a payment of $50 to a Non-Contract Provider Deductible for Covered Expenses would count toward the $128 Deductible for Contract Providers. • Charges exceeding any Plan limits on specific benefits and any amounts you pay for failure to comply with the Plan's requirements for Utilization Review do not count toward the Deductible.	**You Pay** $128 per person $256 per family	**You Pay** $257 per person $514 per family

Benefit Description	Explanations and Limitations	Benefits for Non-Medicare Eligible Retirees and Dependents Contract Providers	Benefits for Non-Medicare Eligible Retirees and Dependents Non-Contract Providers
Coinsurance Maximum The Coinsurance Maximum is the most you pay during a one-year period (calendar year) before your Plan starts to pay 100% for Covered Expenses from Contract Providers.	The following do not count toward the Coinsurance Maximum: • Amounts you pay that are counted toward the Deductible • Amounts you pay for expenses or services that are not covered by the Plan • Charges in excess of benefit limits or Plan maximums (such as the amounts over the Plan's chiropractic maximum of $25/visit, the acupuncture limit, hearing aid, hospice care, and routine physical examination limits) • Premiums • Balance-billed charges • All charges in excess of the Allowed Charge determined by the Plan • Any amounts you have to pay because you did not comply with the Utilization Review requirements of the Plan • Prescription Drugs (including any Copayment and/or Coinsurance amounts) • Expenses incurred by Non-Contract Providers	**You Pay** up to $1,289 per person $2,578 per family	No Coinsurance Maximum

Benefit Description	Explanations and Limitations	Benefits for Non-Medicare Eligible Retirees and Dependents Contract Providers	Benefits for Non-Medicare Eligible Retirees and Dependents Non-Contract Providers
Hospital Services (Inpatient) Room & Board and Ancillary Facility Fees • In a Non-Contract Hospital, a room with 2 or more beds is covered (or the minimum charge for a 2-bed room in the Hospital if a higher priced room is used). • Specialty care units within the Hospital (e.g., intensive care unit, cardiac care unit) are covered. • Lab/x-ray/diagnostic services are covered. • For newborn children, this benefit includes Physician visits in the Hospital and Physician standby charges during a cesarean section.	• Failure to comply with the Plan's requirements for Utilization Review and notification of an Emergency admission may result in services not being covered. • A maximum of $35,000 is payable for the Hospital facility associated with a single hip joint or a single knee joint replacement surgery. • Take-home Drugs dispensed by a Non-Contract Facility are not covered. • Newborn nursery charges are not covered at a Non-Contract Facility.	**You Pay** 10% of the contract rate	**You Pay** 30% plus any amount over the Plan's Allowed Charge
Hospital Surgical Services (Outpatient) For certain surgeries performed in an outpatient hospital instead of an ambulatory service center, a Plan maximum (as outlined in the row to the right) will apply.	• Failure to comply with the Plan's requirements for Utilization Review and notification of an Emergency admission may result in services not being covered. • For the Contract and Non-Contract Hospital/Facility charge, the following maximum payments apply. You pay your applicable Coinsurance and any amount over the following Plan maximum payment: • Colonoscopy - $1,500 • Arthroscopy - $6,000 • Cataract Surgery - $2,000 • All other Endoscopies - $1,000 • Laparoscopic gall bladder - removal - $5,000 • Hysteroscopy uterine tissue sample (with biopsy, with or without dilation and curettage) - $3,500 • Nasal/Sinus - submucous resection inferior turbinate services - $3,000 • Tonsillectomy and/or adenoidectomy (for a Member under age 12) - $3,000 • Nasal/sinus - corrective surgery – septoplasty - $3,500 • Lithotripsy - $7,000 • Hernia inguinal repair (over age 5, non-laparoscopic) - $4,000	**You Pay** 10% of the contract rate	**You Pay** 30% plus any amount over the Plan's Allowed Charge

Benefit Description	Explanations and Limitations	Benefits for Non-Medicare Eligible Retirees and Dependents Contract Providers	Benefits for Non-Medicare Eligible Retirees and Dependents Non-Contract Providers
	• Esophagoscopy - $2,000 • Repair of laparoscopic inguinal hernia - $5,500 • Sigmoidoscopy - $1,000 • Upper gastrointestinal endoscopy without biopsy - $1,500 • Upper gastrointestinal endoscopy with biopsy - $2,000 • Single knee replacement - $35,000 • Single hip replacement - $35,000		
Emergency Room Facility • Hospital Emergency Room (ER) if services are for an Emergency (as that term is defined in this Plan). • Ancillary charges (such as lab or x-ray) performed **during** the Emergency Room visit. • Emergency Services furnished by a Non-Contract Provider or Non-Contract Emergency facility. This includes post-stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the Emergency medical condition, until: - The provider/facility determines that you or your Dependent is able to travel using nonmedical transportation or Non-Emergency medical transportation; - you or your Dependent is supplied with a written notice that the provider is a Non-Contract Provider; of the estimated charges for treatment and any advance limitations that the Plan may put on your treatment; of the names of any Contract Providers at the facility who are able to treat you, and that you may elect to be referred to one of the Contract Providers listed; - you or your Dependent is in a condition to receive the written notice (as determined by the	• Your cost sharing amount for Emergency Services at Contract Facilities by Non-Contract Providers will be based on the lesser of billed charges from the provider or the Qualifying Payment Amount. • Emergency Services are covered without the need for any prior authorization and without regard to whether the provider furnishing the Emergency Services is a Contract Provider or a Contract Emergency Facility; • For subsequent inpatient confinements, the Plan may require that you transfer to a Contract Hospital upon the advice of a Physician that it is medically safe to transfer you or your Dependent and the acute Emergency period has ended. If you remain in the Non-Contract Hospital after the acute Emergency period, the non-contract benefit will apply for the period of confinement after the Emergency period has ended.	**You Pay** 10% of the contract rate **You Pay** Zero if Emergency is for mental health or chemical dependency	**You Pay** 10% of Allowed Charge **You Pay** Zero if Emergency treatment is for mental health or chemical dependency

Benefit Description	Explanations and Limitations	Benefits for Non-Medicare Eligible Retirees and Dependents Contract Providers	Benefits for Non-Medicare Eligible Retirees and Dependents Non-Contract Providers
treating provider), and to provide informed consent; and - you or your Dependent gives informed consent to continued treatment that is not considered Emergency Services by the Non-Contract Provider.			
Physician and Other Health Care Practitioner Services • Physician • Registered physical therapist, occupational therapist services required for the treatment of a medical condition and prescribed by a Physician. Allowed Charges do not include services that are primarily educational, sports-related, or preventive, such as, physical conditioning, exercise, or back school. • Licensed Podiatrist • Registered nurse • Certified nurse-midwife for obstetrical care during the pre-natal, delivery and post-partum periods provided the midwife is practicing under the direction and supervision of a Physician. • Licensed nurse practitioner who is acting within the lawful scope of his/her license; provided the service of the nurse practitioner is in lieu of the service of a Physician, and the nurse practitioner is performing services under the supervision of a licensed Physician, if supervision is required • Licensed Physician assistant • Licensed speech therapist • Licensed optometrist, but only when providing Medically Necessary medical treatment to the eye that is not covered by the vision Plan	• If Medically Necessary outpatient services are provided from a Non-Contract Provider who is not registered with CMS, the Plan will limit allowed charges to $200 per appointment. In-patient services from a Non-Contract Provider not registered with CMS will not be covered. • If a Medically Necessary service is not available from a Contract Provider, the Contract Provider Deductible and percentage payable will apply to Non-Contract Provider Allowed Charges. • Habilitative care is not covered (except for therapy that is being done as part of an approved autism plan).	**Plan Pays** 90% of the contract rate **You Pay** 10% of the contract rate	**Plan Pays** 70% of Allowed Charge **You Pay** 30% of Allowed Charge

Benefit Description	Explanations and Limitations	Benefits for Non-Medicare Eligible Retirees and Dependents Contract Providers	Benefits for Non-Medicare Eligible Retirees and Dependents Non-Contract Providers
Physician Visit on-line LiveHealth: You can talk to a doctor any time of day, face-to-face on your computer or mobile device by two-way video chat. Other online doctor visits covered as regular Plan benefits	Website for LiveHealth online doctor visit is: www.livehealthonline.com Other online doctor visits are covered as regular Plan benefits when received from a Contract Provider.	**On-line physician visits (**with Contract Providers other than LiveHealth Online): **Plan Pays** 90% **You Pay** 10% **LiveHealth Online visits:** **Plan Pays** 100% **You Pay** 0%	**Not Covered**
Acupuncture Services	Acupuncture services are limited to 20 visits per calendar year.	**Plan Pays** 90% of the contract rate up to a maximum of $35 per visit **You Pay** 10% of the contract rate and any amount over the Plan maximum payment of $35	**Plan Pays** 70% of the Allowed Charge up to a maximum of $35 per visit **You Pay** 30% of the Allowed Charge and any amount over the Plan maximum payment of $35
Ambulance Services • Medically Necessary service for ground transportation to or from the nearest Hospital. • A licensed air ambulance to and from the nearest Hospital is also covered at the Allowed Charge if the Fund determines that the location and nature of the Illness or Injury made air transportation cost-effective or necessary to avoid the possibility of serious complications or loss of life. • Services provided by an Emergency Medical Technician (EMT) without subsequent Emergency transport are paid in accordance with this ambulance services benefit	• Expenses for ambulance services are covered only when those services are for an Emergency as that term is defined in the Definitions in the Rules and Regulations Section 1 of this book under the heading of "Emergency Care," or for Medically Necessary inter-facility transport. • If you receive air ambulance services (that are otherwise covered) from a Non-Contract Provider: – Your Cost-Sharing will be no greater than the Cost-Sharing for air ambulance furnished by a Contract Provider (equal to the lesser of the Qualifying Payment Amount or the billed amount for the services).	**Plan Pays** 90% of the contract rate **You Pay** 10% of the contract rate	**Plan Pays** 90% of the Allowed Charge **You Pay** 10% of the Allowed Charge

Benefit Description	Explanations and Limitations	Benefits for Non-Medicare Eligible Retirees and Dependents Contract Providers	Benefits for Non-Medicare Eligible Retirees and Dependents Non-Contract Providers
	– In general, you cannot be balance billed for these services. • Any Cost-Sharing for covered air ambulance services will count toward your contract Deductible and contract Coinsurance Maximum.		
Outpatient (Ambulatory) Surgery Facility/Center Ambulatory (outpatient) surgical facility/center (e.g. surgicenter, same day surgery, outpatient surgery).	The following maximums payable apply if the surgery is performed in an outpatient Hospital setting **instead** of an ambulatory surgery center. The maximums below will not apply if the surgery is performed at an ambulatory surgery center: • Colonoscopy - $1,500 • Arthroscopy - $6,000 • Cataract Surgery - $2,000 • All other Endoscopies - $1,000 • Laparoscopic gall bladder - removal - $5,000 • Hysteroscopy uterine tissue sample (with biopsy, with or without dilation and curettage) - $3,500 • Nasal/Sinus - submucous resection inferior turbinate services - $3,000 • Tonsillectomy and/or adenoidectomy (for a Member under age 12) - $3,000 • Nasal/sinus - corrective surgery – septoplasty - $3,500 • Lithotripsy - $7,000 • Hernia inguinal repair (over age 5, non-laparoscopic) - $4,000 • Esophagoscopy - $2,000 • Repair of laparoscopic inguinal hernia - $5,500 • Sigmoidoscopy - $1,000 • Upper gastrointestinal endoscopy without biopsy - $1,500 • Upper gastrointestinal endoscopy with biopsy - $2,000 • Single knee replacement - $35,000 • Single hip replacement - $35,000	**Plan Pays** 90% of the contract rate **You Pay** 10% of the contract rate	**Plan Pays** 70% of the Allowed Charge up to a maximum of $300 for the ambulatory surgery facility **You Pay** 30% of the Allowed Charge and any amount over the Plan maximum payment of $300

Benefit Description	Explanations and Limitations	Benefits for Non-Medicare Eligible Retirees and Dependents Contract Providers	Benefits for Non-Medicare Eligible Retirees and Dependents Non-Contract Providers
Chemotherapy	The following Specialty Drugs are covered under either the Indemnity medical Plan benefit or the prescription Drug benefit. If filled under the prescription Drug benefit, it will be subject to the prescription Drug Copayments. Regardless of whether the Drug is covered under the medical Plan or the prescription Drug Plan Utilization Review will be required. • Zirabev or generic Mvasi bevacizumab • Uplizno (or generic ipilimumab) • Keytruda (or generic pembrolizumab) • Herceptin (or generic trastuzumab) • Rituxan (or generic rituximab) • Prolia (or generic Xgeva denosumab) • Opdivo (or generic nivolumab) • Lupron (or generic leuprorelin)	**Plan Pays** 90% of the contract rate **You Pay** 10% of the contract rate	**Plan Pays** 70% of Allowed Charge **You Pay** 30% of Allowed Charge
Chiropractic Services (for Retiree and Spouse or Domestic Partner only)	• Chiropractic services are not covered for Dependent Children. • Limited to 20 visits per calendar year	**Plan Pays** 90% of the contract rate up to a maximum of $25 per visit **You Pay** 10% of the contract rate and any amount over the Plan maximum payment of $25 per visit	**Plan Pays** 70% of Allowed Charge up to a maximum of $25 per visit **You Pay** 30% of Allowed Charge and any amount over the Plan maximum payment of $25 per visit
Dental Services Services of a Physician (M.D.) or dentist (D.D.S.) treating an Injury to natural teeth.	• Services must be received within 6 months following the date of Injury (applied without respect to when the individual was enrolled in the Plan). • Damage to natural teeth due to chewing or biting is not covered under this benefit. • Dental plates, bridges, crowns, caps or other dental prostheses, services, extraction of teeth or treatment to the teeth or gums	**Plan Pays** 90% of the contract rate **You Pay** 10% of the contract rate	**Plan Pays** 70% of Allowed Charge **You Pay** 30% of Allowed Charge

Benefit Description	Explanations and Limitations	Benefits for Non-Medicare Eligible Retirees and Dependents Contract Providers	Benefits for Non-Medicare Eligible Retirees and Dependents Non-Contract Providers
	other than for tumors and accidental injury are not covered.		
Diabetes Instruction Programs	Coverage is available for diabetes instruction programs recognized by the American Diabetes Association.	**Plan Pays** 90% of the contract rate **You Pay** 10% of the contract rate	**Plan Pays** 70% of Allowed Charge **You Pay** 30% of Allowed Charge
Medical Equipment and Supplies Benefits are payable if the equipment or supply is: • Ordered by a Physician; • of no further use after the medical need ends; • usable only by the patient; • not primarily for the comfort or hygiene of the patient; • not for environmental control; • not for exercise; • manufactured specifically for medical use; • approved as effective and usual and customary treatment of a condition as determined by the Fund; and • not for prevention purposes. Coverage is provided for up to a 31-day supply of Medically Necessary nondurable supplies for home/personal use, including: • Sterile surgical supplies used immediately after surgery • Supplies needed to operate or use covered Durable Medical Equipment or corrective appliances • Supplies needed for use by skilled home health or home infusion personnel, but only during the course of their required services • Dialysis supplies • Diabetic supplies note: • Colostomy and ostomy supplies	Coverage is provided for Medically Necessary nondurable supplies dispensed and used by a Physician or health care practitioner in conjunction with treatment of the covered individual. • Rental charges are covered if they do not exceed the reasonable purchase price of the equipment. • Orthopedic shoes are covered only if they are joined to a brace. • Custom-made orthotics are covered. • Medical appliances, devices, bandages, braces, splints and other supplies or equipment are not covered, except for diabetic supplies. • Supplies that have use when the medical condition ends are not covered under the nondurable medical supply benefit. • Breast pump rental or purchase for females who are breastfeeding is covered. A manual or electric breast pump is covered by the Plan up to a maximum benefit payment of $75 per calendar year.	**Plan Pays** 90% of the contract rate **You Pay** 10% of the contract rate	**Plan Pays** 70% of Allowed Charges **You Pay** 30% of Allowed Charges

Benefit Description	Explanations and Limitations	Benefits for Non-Medicare Eligible Retirees and Dependents Contract Providers	Benefits for Non-Medicare Eligible Retirees and Dependents Non-Contract Providers
Family Planning, Reproductive, Contraceptive, Fertility Services Covered services include: • Sterilization services (e.g., vasectomy, tubal ligation) • Contraception-related services including services in connection with obtaining or removing a prescription contraceptive device or implant • Prescription contraceptives	If Medically Necessary outpatient services are provided from a Non-Contract Provider who is not registered with CMS, the Plan will limit allowed charges to $200 per appointment. In-patient services from a Non-Contract Provider not registered with CMS will not be covered. No coverage is available for reversal of sterilization procedures, infertility treatment, along or with services to induce pregnancy.	**Plan Pays** 90% of the contract rate **You Pay** 10% of the contract rate	**Plan Pays** 70% of Allowed Charge **You Pay** 30% of Allowed Charge
Hearing Exam and Hearing Aid Benefit Covered services include a hearing exam if Medically Necessary and performed by a Physician or healthcare practitioner with a master's or doctoral degree in audiology.	No benefits will be provided for: • The replacement of a hearing aid for any reason more often than once during any 3-year period; • batteries or any other ancillary equipment other than that obtained upon the purchase of the hearing aid; or • expenses incurred for which the individual is not required to pay.	**Exam:** **Plan Pays** 90% **You Pay** 10% **Hearing Aid:** 100% up to a maximum payment of $800 per ear (in any 3-year period), not to exceed Covered Expenses, for the hearing aid and all repairs or servicing. Not subject to Deductible or Coinsurance Maximum.	**Exam:** **Plan Pays** 70% **You Pay** 30% **Hearing Aid:** 100% up to a maximum payment of $800 per ear (in any 3-year period), not to exceed Covered Expenses, for the hearing aid and all repairs or servicing. Not subject to Deductible or Coinsurance Maximum.
Home Health Care and Home Infusion Therapy Services Covered Expenses include: • Services of a registered nurse • Services of a licensed therapist for physical therapy, occupational therapy and speech therapy • Services of a medical social worker • Services of a health aid who is employed by (or contracted with) a Home Health Agency. Services	• The Patient must be confined at home under the active medical supervision of a Physician ordering home health care and treating the Illness or Injury for which that care is needed. • Services must be provided and billed by the Home Health Agency. • Services must be consistent with the Illness, Injury, degree of disability and medical needs of the Patient.	**Plan Pays** 90% of the contract rate **You Pay** 10% of the contract rate	**Plan Pays** 70% of Allowed Charge **You Pay** 30% of Allowed Charge

Benefit Description	Explanations and Limitations	Benefits for Non-Medicare Eligible Retirees and Dependents Contract Providers	Benefits for Non-Medicare Eligible Retirees and Dependents Non-Contract Providers
must be ordered and supervised by a registered nurse employed by the Home Health Agency as a professional coordinator • Necessary medical supplies provided by the Home Health Agency	• Benefits are provided only for the number of days required to treat the Eligible Individual's Illness or Injury. • Injectable and infusion Drugs are not covered under this home health Care benefit. Please see the **Retail Pharmacy** section on page xx prescription Drug section of this Schedule of Medical Benefits for other Drug coverage. • Specialty Drugs must be obtained from the prescription Plan. See the **Specialty Drugs** section beginning on page 71		
Hospice • Hospice services include inpatient hospice care and outpatient home hospice when the Patient has an Illness for which the prognosis for life expectancy is estimated to be 6 months or less, as certified by the Physician. The Patient must be formally admitted to an approved hospice program, and the attending Physician must approve the patient's written treatment program. • An approved Hospice program must meet state licensure requirements as a Hospice (in states with licensure requirements) and be a Medicare-certified Hospice, or a Medicare demonstration Hospice site, or accredited by The Joint Commission (TJC). The Hospice must notify the Fund of a Patient's admission into a Hospice program and submit a written treatment plan to the Fund.	Covered Hospice care services include the following: • Professional nursing visits; • medical social services; • home health aide services; • nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation; and • medical supplies. The Hospice benefit does not cover: • Medical transportation, food, clothes or housing; • volunteer services; • financial or legal counselors; or • services provided by household members or family and friends.	**Plan Pays** 90% of the contract rate **You Pay** 10% of the contract rate	**Plan Pays** 70% of Allowed Charge **You Pay** 30% of Allowed Charge
Laboratory Services (Outpatient) • Technical **and professional fees**	• Services must be ordered by a Physician, including laboratory tests associated with diagnosing a viral illness. • Inpatient laboratory services are covered under the **Hospital Services** section of this Schedule of Medical Benefits.	**Plan Pays** 90% of the contract rate **You Pay** 10% of the contract rate	**Plan Pays** 70% of Allowed Charge **You Pay** 30% of Allowed Charge
Maternity Services • Hospital and birth (birthing) center charges and Physician fees for	• Routine newborn nursery charges billed by a Non-Contract Hospital are NOT covered.	**Plan Pays** 90% of the contract rate	**Plan Pays** 70% of Allowed Charge

Benefit Description	Explanations and Limitations	Benefits for Non-Medicare Eligible Retirees and Dependents Contract Providers	Benefits for Non-Medicare Eligible Retirees and Dependents Non-Contract Providers
Medically Necessary maternity services for all covered pregnant individuals. Coverage for the baby is only payable if the child is a Dependent child as defined in this Plan, and properly enrolled. • Prenatal vitamins containing fluoride or folic acid are covered. • See the Enrollment and **Eligibility** chapter on how to enroll a newborn Dependent child(ren).	• Hospital length of stay for childbirth: For information on Utilization Review for a length of stay longer than 48 hours for vaginal birth or 96 hours for C-section, contact Anthem for Utilization Review for approval of an extended stay.	**You Pay** 10% of the contract rate	**You Pay** 30% of Allowed Charge
Mental Health • Inpatient hospitalization, residential treatment and partial day care • Outpatient visits • The benefits for prescription Drugs for the treatment of mental health are explained in the **Retail Pharmacy** Section on page 72	If Medically Necessary outpatient services are provided from a Non-Contract Provider who is not registered with CMS, the Plan will limit Allowed Charges to $200 per appointment. In-patient services from a Non-Contract Provider not registered with CMS will not be covered. • The Fund provides coverage for Medically Necessary Applied Behavioral Analysis (ABA) therapy in accordance with Anthem guidelines.	**Mental Health outpatient visits:** **Plan Pays** 100% of the contract rate (does not include care in outpatient facilities) **Mental Health inpatient:** **Plan Pays** 90% of the contract rate **You Pay** 10% of the contract rate **Emergency Room treatment:** **Plan Pays** 100% of the contract rate **On-line Physician visits with Contract Providers** (other than LiveHealth Online): **Plan Pays** 90% **You Pay** 10% **LiveHealth Online visits:** **Plan Pays** 100% **You Pay** 0%	**Emergency Room treatment:** **Plan Pays** 100% of Allowed Charge **All other:** **Plan Pays** 70% of Allowed Charge **You Pay** 30% of Allowed Charge **Online visits:** **Not Covered**

Benefit Description	Explanations and Limitations	Benefits for Non-Medicare Eligible Retirees and Dependents Contract Providers	Benefits for Non-Medicare Eligible Retirees and Dependents Non-Contract Providers
Prosthetic Devices	Coverage is available for artificial limbs and/or eyes.	**Plan Pays** 90% of the contract rate **You Pay** 10% of the contract rate	**Plan Pays** 70% of Allowed Charge **You Pay** 30% of Allowed Charge
Radiology (X-Ray), Imaging Studies and Radiation Therapy Services (Outpatient) Common radiology services include: Chest x-ray; abdomen/kidney x-ray; spine x-ray; CT/MRI/PET and bone scan; ultrasound; angiography; mammogram; fluoroscopy; and bone densitometry.	• Covered only when ordered by a Physician or health care practitioner. • For the following outpatient diagnostic imaging services, a Physician must obtain Utilization Review from the Professional Review Organization (Anthem): – CT/CTA – MR/MRI – Nuclear cardiology – PET scan – Echocardiography	**Plan Pays** 90% of the Contract Rate **You Pay** 10% of the contract rate	**Plan Pays** 70% of Allowed Charge **You Pay** 30% of Allowed Charge
Skilled Nursing Facility (SNF) including Rehabilitation Services • Skilled Nursing Facility (SNF) • Services of a licensed therapist for physical therapy or occupational therapy • Services of a licensed speech therapist only for speech therapy that is provided to an Eligible Individual who had normal speech at one time and lost it due to an Illness or Injury or as part of an approved autism plan	• Benefits will be paid for Skilled Nursing Facility and home health care as an alternative to Hospital care when the care is arranged by the attending Physician. • A maximum of 70 days of Skilled Nursing Facility care will be covered during any Period of Confinement. A new Period of Confinement will begin after 90 days have passed since the end of the last confinement in a Skilled Nursing Facility. • Inpatient Rehabilitation admission requires Utilization Review from Anthem. • Physical therapy services that are primarily educational, sports related or preventive, such as physical conditioning, exercise or back school are not covered. • Habilitative services are not covered (except for therapy that is being done as part of an approved autism plan). This includes any physical therapy, occupational therapy, and/or speech therapy provided to individuals with developmental delays that have never acquired normal functional abilities	**Plan Pays** 90% of the contract rate **You Pay** 10% of the contract rate	**Plan Pays** 70% of Allowed Charge **You Pay** 30% of Allowed Charge

Benefit Description	Explanations and Limitations	Benefits for Non-Medicare Eligible Retirees and Dependents Contract Providers	Benefits for Non-Medicare Eligible Retirees and Dependents Non-Contract Providers
Smoking Cessation Treatment	Counseling and interventions for tobacco use (both smoking and chewing tobacco) are covered as follows: • Screening for tobacco use; and, • for tobacco users, at least two (2) tobacco cessation attempts per year. Each "tobacco cessation attempt" includes coverage for four (4) tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and all FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a Contracted health care provider.	**Plan Pays** 100% of the contract rate	**Not covered**
Substance Abuse Treatment • Inpatient hospitalization, residential treatment and partial day care • Outpatient visits The benefits for prescription Drugs for substance abuse are explained in the **Retail Pharmacy** section beginning on page 72	If Medically Necessary outpatient services are provided from a Non-Contract Provider who is not registered with CMS, the Plan will limit allowed charges to $200 per appointment. In-patient services from a Non-Contract Provider not registered with CMS will not be covered.	**Inpatient and outpatient treatment:** **Plan Pays** 100% of the contract rate **Emergency room treatment:** **Plan Pays** 100% of the contract rate **All other:** **Plan Pays** 90% of the contract rate **You Pay** 10% of the contract rate	**Emergency room treatment:** **Plan Pays** 100% of Allowed Charge **All other:** **Plan Pays** 70% of Allowed Charge **You Pay** 30% of Allowed Charge
Transplants (Organ and Tissue) Allowed Charges incurred by the donor and the recipient when the recipient is an Eligible Individual.	• All benefits for transplants must receive Utilization Review from Anthem. • In no case will the Plan cover expenses for transportation of	**Plan Pays** 90% of the contract rate	**Plan Pays** 70% of Allowed Charge

Benefit Description	Explanations and Limitations	Benefits for Non-Medicare Eligible Retirees and Dependents Contract Providers	Benefits for Non-Medicare Eligible Retirees and Dependents Non-Contract Providers
Allowed Charges may include Patient screening, organ procurement and transportation of organ or tissue, surgery and Hospital charges for the recipient and donor, follow-up care in home or Hospital, and immunosuppressant Drugs. • Benefits payable for an organ donor who is not an Eligible Individual will be reduced by any amounts paid or payable by that donor's own health coverage.	the donor, surgeons or family members. The following criteria must be met for any transplant benefits to be payable: • The transplantation procedure is not considered an Experimental or Investigative Procedure as defined in **Article 1: Definitions** in this document; • the Patient is admitted to a transplantation center program in a major medical center approved either by the Federal government or the appropriate state agency of the state in which the center is located; and • the recipient of the organ or tissue is an Eligible Individual covered under the Plan.	**You Pay** 10% of the contract rate	**You Pay** 30% of Allowed Charge
Wellness (Preventive Care) and Vaccines and Immunization for Children • Vaccines and immunizations for children from birth to age 18. Recommendations for doses, recommended ages, and recommended populations must be satisfied.	• Deductible does not apply to the following vaccines and immunizations received fromwith a Contract Provider: Hepatitis B; Rotavirus; Diphtheria; Tetanus; Pertussis; Haemophilus influenzae type b; Pneumococcal; Inactivated Poliovirus; Influenza; Measles; Mumps; Rubella; Varicella; Hepatitis A; Meningococcal; Human papillomavirus (HPV) and COVID-19.	**No Charge**	**Not Covered**
Wellness (Preventive) Program for Retiree and Spouse Normal Plan benefits including Deductible, and Coinsurance apply to most covered preventive services. • Should you choose to receive a flu vaccine at your pharmacy, you may submit your Claim for reimbursement to the Fund Office by providing the following information: 1) A copy of your receipt that includes the name of the person receiving the vaccine; 2) The date the vaccine was administered; and 3) The amount paid.	The Plan will cover: • A routine physical examination for the Retiree and the Spouse limited to one in any 12-month period (including all lab tests and x-rays provided as part of the exam). • Routine preventive care may include a colonoscopy and sigmoidoscopy examination if your Physician considers you at high risk for colon cancer. • A routine OB/GYN examination provided by a Physician once within any 12-month period for the Retiree and Spouse only. Coverage includes any x-rays and laboratory tests provided in connection with the physical	**Vaccines and Immunizations:** **No charge** **All other:** **Plan Pays** 90% of the contract rate **You Pay** 10% of the contract rate There is a $1,500 maximum for a colonoscopy received in an	**Vaccines and Immunizations:** **Not covered** **All other:** **Plan Pays** 70% of Allowed Charge **You Pay** 30% of Allowed Charge There is a $1,500 maximum for a colonoscopy received in an

Benefit Description	Explanations and Limitations	Benefits for Non-Medicare Eligible Retirees and Dependents Contract Providers	Benefits for Non-Medicare Eligible Retirees and Dependents Non-Contract Providers
Also, please include a copy of your medical card. • Vaccines and/or Immunizations, including travel immunizations, included in the Express Scripts comprehensive vaccine coverage program will be covered at 100%, with no Copayment when received from a Participating Pharmacy. A list of immunizations covered under this program is available from Express Scripts.	examination, including pap smears. Deductible does not apply. • A routine mammogram, including a digital mammogram, obtained as a diagnostic screening procedure. Benefits will be paid in accordance with the following frequency schedule: – Women age 35 through 39: One baseline mammogram – Women ages 40 and over: One mammogram every year • Should you choose to receive a flu vaccine at your pharmacy, you may submit your Claim for reimbursement to the Fund Office by providing the following information: 1) A copy of your receipt that includes the name of the person receiving the vaccine; 2) The date the vaccine was administered; and 3) The amount paid. Also, please include a copy of your medical card. • Vaccines and/or Immunizations including travel immunizations, included in the Express Scripts comprehensive vaccine coverage program will be covered at 100%, with no Copayment **when received from a Participating Pharmacy**. A list of immunizations covered under this program is available from Express Scripts. • Routine preventive care may include a colonoscopy and sigmoidoscopy examination if your Physician considers you at high risk for colon cancer. • A routine mammogram, including a digital mammogram, obtained as a diagnostic screening procedure. Benefits will be paid in accordance with the following frequency schedule: – Women age 35 through 39: One baseline mammogram	outpatient Hospital setting	outpatient Hospital setting

Benefit Description	Explanations and Limitations	Benefits for Non-Medicare Eligible Retirees and Dependents Contract Providers	Benefits for Non-Medicare Eligible Retirees and Dependents Non-Contract Providers
	– Women ages 40 and over: One mammogram every year • Deductible does not apply to the following vaccines and immunizations received with a Contract Provider: Diphtheria/tetanus/pertussis; Measles/mumps/rubella (MMR); flu; Human papillomavirus (HPV); Pneumococcal (polysaccharide); Zoster; Hepatitis A; Hepatitis B; Meningococcal; Varicella; and COVID-19.		

Retail Pharmacy Program

The Plan will provide up to a 30-day supply of medication per prescription through the retail pharmacy program. Not all medications are eligible for coverage. If you need to take maintenance medications on an ongoing basis, you must use the mail order pharmacy or one of Express Scripts' Smart 90 pharmacies to receive up to a 90-day supply and avoid additional cost. Please contact Express Scripts at (800) 939-7093 for a list of Smart 90 pharmacies.

When you are eligible for coverage, your medical identification card will have your prescription Drug information on it and can be used as your prescription ID card. If you live within 10 miles of a network pharmacy, you must use a network pharmacy for retail pharmacy services.

- Show the pharmacist your ID card; and
- pay your Copayment for the prescription (the pharmacy bills the Plan the remaining amount).
- If you fail to show your medical identification card to the network pharmacist, you must pay the pharmacy the full price for the prescription. You may then send a Claim form to Express Scripts for reimbursement. Express Scripts will reimburse you based on the amount the Fund would have paid if your prescription were filled at a network pharmacy and you will be responsible for any remaining charges.
- The **"Formulary"** is the list of preferred Drugs established by Express Scripts' independent pharmacy & therapeutics committee. The committee reviews Drugs on the preferred list based on safety, efficacy and cost.
- The pharmacist will automatically fill your prescription with a Formulary Generic Drug if available unless you or your doctor specify otherwise. Retail Drugs fall under one of four categories shown below:
- "**Brand Name**" is a Drug sold by a specific Drug company that is protected by patent.
- "**Generic**" is a Drug that is created to be the same as a brand name Drug that is typically available at a lower cost.
- **"Multi-source"** is a brand name Drug that has a generic equivalent.
- **"Single-source"** is a brand name Drug that does not have a generic equivalent.
- Express Scripts has implemented a number of programs to help keep your (and also the Fund's) costs down for your prescription Drugs. If you attempt to fill a prescription for:
- A non-preferred alternative Drug;
- a Drug not approved through the step therapy program;
- a Drug requiring preauthorization when preauthorization is not obtained;
- a medication that has not been approved by the Food and Drug Administration for any indication; or
- any other medication that does not satisfy the United Brotherhood of Carpenter's Clinical Advisory Committee's criteria for coverage or Express Scripts' clinical guidelines or safety or cost saving protocols, there will be **no payment** by the Fund. This does not mean you should stop taking your medication; we recommend that you talk to your doctor to discuss alternative medication options.

Note: The Formulary includes at least one Drug choice, and in most cases multiple Drug choices, for each therapeutic category.

If you have any questions regarding your prescription Drug coverage, including questions regarding medications covered under the program, please contact Express Scripts at (800) 939-7093 or visit www.express-scripts.com.

If There is No Network Pharmacy in Your Area

The Plan will reimburse you for covered prescriptions filled at a non-network pharmacy **only if you live more than 10 miles from the closest network pharmacy**. Your pharmacist must complete a prescription Drug Claim form, which is available from the Fund Office. Covered Drugs will be reimbursed at 100% of the reasonable cost less the applicable Copayment and any other amount due from you, as shown above. You will be responsible for any charges above the reasonable cost.

Mail Order and Smart 90 Program

Maintenance medications are prescription Drugs that are used on an ongoing basis. The Plan requires that all maintenance medications must be obtained through mail order or from pharmacies participating in the Smart 90 program. You can save money for your maintenance medications and receive a fill of the medication for up to a 90-day supply. Your prescription will be filled with a generic Drug if available unless your doctor indicates no substitution may be made.

To reduce the cost of your maintenance medication, you must use a Smart-90 pharmacy or the mail order program after you obtained two prescriptions for any maintenance medication. If you do not, you will be required to pay the difference between the cost of medication available by mail-order or by a Smart-90 pharmacy and the retail pharmacy's charge.

To use the mail order program:

- Ask your doctor for a prescription for up to a 90-day supply, with refills if appropriate.
- Mail the original prescription along with the prescription order form and your payment or credit card information to Express Scripts. You may also have your doctor fax your prescriptions. Ask your doctor to call Express Scripts at (800) 473-3455 for faxing instructions.
- To use the Smart-90 program:
- Ask your doctor for a prescription for up to a 90-day supply, with refills if appropriate.
- Take the prescription to a retail pharmacy that is on the Smart-90 list. For a list of Smart-90 pharmacies, call Express Scripts at (800) 939-7093.
- If you need to begin taking the medication right away and choose to use the mail order pharmacy, you may want to ask your doctor for two prescriptions: A short-term supply that you can have filled immediately at a network retail pharmacy; and a refillable supply that you can have filled through the mail order program.

With the Mail Order Option and Smart-90 Option you can choose your way to save with a 3-month supply:

Express Scripts Pharmacy Mail Order	Participating Smart-90 Retail Pharmacies
Delivered to your door with free standard shipping	At convenient locations near you
Transfer prescriptions easily online by phone or Express Scripts mobile app	Transfer prescriptions easily in-store, by phone or online
Auto-refills and refill reminders available	Ask about auto refills and refill reminders
Talk with a pharmacist by phone 24/7	Call Express Scripts for a list of participating pharmacies in your area

Specialty Drugs

Specialty Drugs are infrequently used, expensive medications. To control costs for you and the Plan, a specific pharmaceutical provider is used to supply these expensive Drugs. Patients must obtain Specialty Drugs through the Plan's assigned Specialty Drug pharmacy, which is currently Accredo. **Specialty Drugs billed by retail pharmacies, doctor offices, or by a hospital are not covered.**

Limitations on Specialty Drugs

- Specialty Drugs are covered only if they are obtained from the Express Scripts specialty care pharmacy, Accredo. These Drugs will not be available from a retail network pharmacy and will not be covered by the Indemnity medical Plan except certain oncology and Emergency Drugs. The list of Specialty oncology Drugs also covered under the medical Plan can be found under "Chemotherapy" in the Schedule of Indemnity Medical Plan Benefits section of this booklet. Couldn't find Emergency Drugs that may be provided by a retail network pharmacy are those such as low molecular weight heparin products that are used for blood clots after hip replacement surgery.

You will be responsible for any remaining charges if Specialty Drugs are obtained from any source other than Express Scripts' specialty care pharmacy.

- Benefits for Specialty medications not obtained from Express Scripts' specialty care pharmacy Accredo will be limited to what the Fund would have paid if the Drug had been obtained through Express Scripts, and you will be responsible for any remaining charges.

The following chart outlines how much you will have to pay for covered prescription Drugs. If the cost of the Drug is less than the Copayment, you pay just the Drug cost:

Prescription Drug Benefits for Retirees and Dependents Not Eligible for Medicare			
Drugs (Outpatient Medicines) Please refer to the **Retail Pharmacy** section beginning on page 70	**In-Network Retail Pharmacy** (up to a 30-day supply)	Formulary Generic Drug	$15 Copayment
		Multi-Source Brand Name Drug	$15 plus the difference in cost between the generic and brand name Drug
		Single Source Formulary Brand Name Drug	$53 Copayment
		Non-Formulary Drug	$80 Copayment, provided the Drug has been approved or does not require Utilization Review

Prescription Drug Benefits for Retirees and Dependents Not Eligible for Medicare			
		For any new brand name Drug approved by the FDA, the Copayment is 50% of the cost of the Drug for a minimum of 24 months after the Drug has been approved. If Express Scripts determines that the new FDA approved Drug is a "must not add" Drug, the Copayment will remain at 50% of the cost of the Drug.	
		You pay 100% if you use a non-network pharmacy unless there are no network pharmacies available within 10 miles. The Plan will reimburse up to the amount it would have paid had you used an in-network pharmacy.	
	Mail Order Services or Smart 90 Retail Pharmacies found online at express-scripts.com/90day (up to a 90-day supply)	Formulary Generic Drug	$26 Copayment
		Multi-Source Brand Name Drug	$26 plus the difference in cost between the generic and brand name Drug
		Single Source Formulary Brand Name	$106 Copayment
		Non-Formulary Drug	$133, provided the Drug has been preauthorized or does not require Utilization Review
	Specialty Drugs (up to a 30-day supply)	Formulary Generic Drug	$15 Copayment
		Multi-Source Brand Name Drug	$26 plus the difference in cost between the generic and brand name Drug
		Single Source Formulary Brand Name	$53 Copayment
		Non-Formulary Drug	$80 Copayment, provided the Drug has been approved or does not require Utilization Review
		For any new brand name Drug approved by the FDA (including injectable and infusion Drugs), the Copayment is 50% of the cost of the Drug for a minimum of 24 months after the Drug has been approved. If Express Scripts determines that the new FDA approved Drug is a "must not add" Drug, the Copayment will remain at 50% of the cost of the Drug.	
	Specialty Drugs must be obtained from the specialty pharmacy vendor, Accredo, or no Plan benefit is available.		
	Smoking Cessation	No charge for FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) for two 90-day treatment regimens when prescribed by a Contract Provider.	
	Routine Vaccines	No charge for the following vaccines and immunizations received at a Participating Pharmacy: Diphtheria/tetanus/pertussis, Measles/mumps/rubella (MMR), flu, Human papillomavirus (HPV), Pneumococcal (polysaccharide), Zoster, Hepatitis A, Hepatitis B, Meningococcal, Varicella and COVID-19.	

Prescription Drug Exclusions

Not all medications are approved for coverage. Medications excluded under the pharmacy benefit manager's (PBM) pharmacy and therapeutics committee or United Brotherhood of Carpenter's (UBC) Clinical Advisory Committee are not covered. For a list of covered medications, please logon to your Express Scripts account at www.express-scripts.com.

No benefits are payable under the prescription Drug benefit for the following:

1. Drugs taken or administered while the Patient is Hospital confined.

2. Patent or proprietary medicines which do not conform to the definition of "Drugs" set forth in the Rules and Regulations except insulin, insulin injection kits, and other Medically Necessary diabetic supplies.
3. Appliances, devices, bandages, heat lamps, braces, splints, and other supplies or equipment.
4. Vitamins (except prenatal vitamins containing fluoride or folic acid), cosmetics, dietary supplements, health and beauty aids.
5. Charges for prescription Drugs containing in excess of a 30-day supply for retail purchase, or in excess of a 90-day supply for Drugs purchased through the Fund's mail order or Smart 90 Drug programs.
6. Infertility Drugs.
7. Nose drops or other nasal preparations.
8. Appetite suppressants, or any other weight loss Drug.
9. Drugs prescribed for hair growth or any medications prescribed for cosmetic purposes.
10. Any Drugs not Medically Necessary for the care or treatment of an Illness or Injury.
11. Any Drugs obtained at a Non-Participating Pharmacy if the Eligible Individual resides within 10 miles of a Participating Pharmacy.
12. Replacement Drugs resulting from loss, theft or breakage.
13. Prescription refills dispensed after 1 year from original date of dispensing.
14. Injectable sexual dysfunction Drugs. Other sexual dysfunction Drugs are limited in the quantity covered. The maximum quantity is 8 units within a rolling 30-day period or 24 units within a rolling 90 day period.
15. Medications with no Federal Food and Drug Administration (FDA) approved indications.
16. Medications used for Experimental indications and/or dosage regimens determined to be Experimental or Investigational; any Investigational or unproven Drugs or therapies.
17. The third purchase of a long-term maintenance Drug from a retail pharmacy. After the second purchase of long-term maintenance Drug at a retail pharmacy, the Drug must be purchased from the pharmacy benefit manager's mail order pharmacy or a Smart 90 retail pharmacy.
18. Provided that notice is issued by the Plan to an Eligible Individual, a single pharmacy may be designated as the sole provider to dispense one or more prescription Drug class(es) to a Participant and/or Dependent. Medications dispensed by pharmacies other than named in such notice are excluded.
19. Compound dermatologist preparations prescribed by a Physician.
20. Any medications that do not meet the Express Script's clinical guidelines.
21. Any medications that do not satisfy the Express Script's prior authorization requirements, step therapies, therapeutic guidelines or other safety and cost saving protocols.
22. Stem cell treatment without Federal Food and Drug Administration (FDA) approval.

Vision Benefits

Copayments/Schedule of Benefits

You pay the Copayment regardless of whether you use a VSP participating provider or a non-participating provider. The $10 exam Copayment is due only once each year, for the first service you receive each year (unless you qualify for the low vision benefit, which has additional Copayments).

Vision Benefits	VSP Member Doctor	Non-VSP Provider
Copayments for: • Exam • Materials (Prescription Glasses)	**You Pay** $10 $25	**You Pay** $10 $25
Vision Examination – Limited to once every 12 months	**Plan Pays** 100%	**Plan Pays** up to $40
Lenses – Limited to once every 12 months	**Plan Pays** 100%	**Plan Pays** up to: Single Vision: $40 Lined Bifocal: $60 Lined Trifocal: $80 Lenticular: $100 Tints: **Not covered**
Frames – Limited to once every 24 months	**Plan Pays** 100%, up to $175 retail allowance	**Plan Pays** up to $45
Necessary Contact Lenses – Limited to once every 12 months (in lieu of lenses and frames)	**Plan Pays** 100%	**Plan Pays** up to $210
Elective Contact Lenses – Limited to once every 12 months (in lieu of lenses and frames)	**Plan Pays** Up to $155 for contact lenses and fitting and evaluation exam	**Plan Pays** Up to $105 for contact lenses and fitting and evaluation exam
Costco Frame Allowance	**Plan Pays** $95	N/A

Covered Vision Services

- Vision Examination – including analysis of visual functions and prescription of corrective eyewear when indicated, once every 12 months.
- Lenses – once every 12 months for regular every day wear lenses and once every 12 months for safety glasses.
- Frames – once every 24 months for regular every day wear frames and once every 24 months for safety glasses. VSP offers a selection of frames within Plan limits. If you choose more expensive frames (exceeding the Plan limit), you will be responsible for the additional amount over the Plan's maximum.
- Visually Necessary Contact Lenses – once every 12 months. Visually necessary contacts obtained from a VSP participating provider are covered in full. When they are obtained from a non-VSP provider, a benefit up to $210 will be paid toward the cost. Contact lenses are visually necessary if they are needed to restore or maintain visual acuity and a less expensive professionally acceptable alternative is not available. Visually necessary contact lenses are subject to the exam and materials Copayments.

> Contact lenses are provided in lieu of all other benefits for lenses and frames and only when a prescription change is warranted.

- Elective Contact Lenses – once every 12 months. If you choose contact lenses for any purposes other than the visually necessary circumstances described above, they are considered elective contact lenses. When you choose contact lenses instead of glasses, your $155 allowance applies to the cost of the contacts and the contact lens exam and fitting evaluation. This is in addition to your regular vision exam, which is covered in full (if from a VSP participating provider). When contact lenses are obtained, you will not be eligible for regular spectacle lenses again for 12 months and frames for 24 months. (Note: The exam and materials Copayments do not apply to elective contact lenses.)

Discounts From VSP Participating Providers

When you use a VSP participating provider, you will be entitled to discounts on charges for some non-covered items and contact lenses. These discounts include:

- 20% off for additional prescription glasses and sunglasses when a complete pair of glasses is dispensed – available within the last 12 months of the well Vision Exam.
- 30% average savings on popular lens options, such as scratch resistant and anti-reflective coatings and progressives.
- 15% discount off cost of contact lens exam (fitting and evaluation).

Exclusions and Limitations

When you select any of the following extra items, the Plan will pay the basic cost of the allowed lenses or frame, and you must pay any additional cost for the options, including:

- Optional cosmetic processes
- Anti-reflective coating
- Color coating, mirror coating or scratch coating
- Blended lenses
- Cosmetic lenses, laminated lenses, or oversize lenses

- Polycarbonate lenses (covered for Dependent children)
- Premium and custom progressive multifocal lenses
- UV (ultraviolet) protected lenses
- A frame that costs more than the Plan allowance

Services Not Covered

There are no benefits payable under the vision benefit for professional services or materials connected with:

- Orthoptics or vision training and any supplemental testing; plano lenses (less than a +.50 diopter power); or 2 pair of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this Plan that are lost or broken; except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Services that can be obtained without cost from any federal, state, county or local organization or agency.
- Corrective vision treatment of an Experimental nature.
- Costs for services and/or materials above Plan benefit allowances.

Low Vision Benefit

The Low Vision Benefit is available if you have severe visual problems that cannot be corrected with regular lenses. If you qualify for this benefit, you may receive professional services as well as ophthalmic materials, including supplemental testing, evaluations, visual training, low vision prescription services and optical and non-optical aids, subject to the maximums outlined in the following chart:

Low Vision Benefits	VSP Member Doctor	Non-Member Doctor
Supplemental testing	**Covered in full**	**Plan Pays** up to $125
Supplemental Aids	**Plan Pays** 75% of the approved cost	**Plan Pays** 75% of the approved cost
Maximum Benefit	**Plan Pays** $500 per person, every two (2) years (Dependent children under age 19 are not subject to the $500 maximum)	**Plan Pays** $500 per person, every two (2) years

How to File a Claim

If you use a non-VSP provider, call VSP at (800) 877-7195 to have an Out-of-Network Reimbursement Form mailed or faxed to you. (You can also fill out the form online at www.vsp.com and print it.) Mail the completed form with your itemized receipt to VSP at:

Vision Service Plan
Attn: Out-of-Network Provider Claims
P.O. Box 495918
Cincinnati, OH 45249-5918

When you use a VSP Participating Provider, you do not need to file a Claim for reimbursement.

To locate a VSP provider, call VSP at (800) 877-7195 or search online at www.vsp.com.

Appeals for Denied Vision Care Benefits

If your Claim is denied, in whole or in part, you will receive written notification from VSP including the reasons for denial. If you do not agree with the denial you may then submit a written request to VSP for reconsideration within 180 days from the date you received the denial. Any request for reconsideration should include documents or records in support of your appeal. VSP will provide a written response to the appeal within 30 days after it is received.

Any request to VSP should be sent to the following address:

Vision Service Plan Member Appeals 3333 Quality Drive
Rancho Cordova, CA 95670 (800) 877-7195

See the brochure from VSP and "**Claims and Appeals Procedures**" beginning on page 96 of this booklet.

Vision Plan benefits are treated as standalone (or excepted) benefits under the Health Insurance Portability and Accountability Act (HIPAA) and the Patient Protection and Affordable Care Act of 2010 (PPACA). Even though the Fund is not required to do so under PPACA, the Fund offers vision Plan benefits for covered Dependents.

Section 3 - Indemnity Medical Plan For Retirees With Medicare

This section includes:

- An overview of how the Indemnity Medical Plan works, including rules and guidelines
- A description of Vision and prescription Drug benefits and rules
- A Schedule of Indemnity Medical Plan Benefits for Retirees with Medicare

Please Note

The benefits in this chapter apply to Retirees or Dependents who are eligible for Medicare under the Indemnity Plan only. If you and your eligible Dependents are covered under the Kaiser HMO plan, please contact Kaiser (at the telephone number listed on the Quick Reference Chart) for a copy of your Evidence of Coverage (EOC) that outlines your medical benefits under the Kaiser HMO plan.

You should be aware that you may have substantial out-of-pocket expenses if you are not enrolled in both Parts A and B of Medicare

As noted under "**Enrollment and Eligibility**" beginning on page 18, it is very important that you enroll for Parts A and B of the Federal Medicare program during the 3 month period before the month in which you will become eligible for Medicare. (This applies to both Retirees and Spouses.) Once you are eligible for Medicare, the Fund will pay the benefits described below as if you had enrolled for both Part A and Part B of Medicare, regardless of whether you are actually enrolled. **This means that if you are not enrolled in Medicare Part A and Part B, the Plan will only pay 20% of Medicare's rates for services and you must pay the rest of the charge.**

Calendar Year Deductible

The Fund will pay the benefits described in this Section after you have met the deductible of $128 each calendar year. The Deductible applies to each covered person.

Inpatient Hospital Benefits

If you are eligible for Medicare and confined in a Hospital, the Plan will pay the Medicare Part A Hospital Deductible for the first 60 days of each Medicare benefit period for covered Hospital services. Medicare Part A Coinsurance days are not covered by this Plan.

Supplemental Benefits for Outpatient Hospital or Facility Services

If you receive outpatient medical or surgical treatment in a Hospital or Facility, and if those services are covered by Part B of Medicare, the Plan will pay the remainder of the Medicare allowable charge after Medicare's payment.

Supplemental Medical Benefits, Including Mental Health and Substance Abuse Treatment

(for other than outpatient Hospital or Facility services)

If you or your Dependent receives medical treatment, medical services or supplies or home health services of the type for which benefits are provided by Part B of Medicare, the Fund will pay either:

- 20% of Medicare's allowable charges, if the provider accepts the Medicare assignment of benefits;
- 20% of the covered Medicare maximum allowable charge incurred, if the provider does not accept the Medicare assignment of benefits; or
- 20% of the Contract Provider negotiated rate, if less than the Medicare allowable charge (California Contract Providers only).

Important Note About Doctors Who Enter Into Private Contracts:

A doctor may opt-out of Medicare reimbursement for Medicare-covered services and enter into a private contract with a Patient. Patients privately pay the doctor out of their own funds—at whatever rate the doctor chooses— even if Medicare would usually cover it. The doctor cannot bill Medicare for the services.

If you go to a doctor that has opted-out of Medicare, the doctor must tell you in advance that you must agree to a "private contract." The "private contract" between you and the doctor must state clearly that:

- You are giving up the right to get Medicare to pay for the services;
- You agree that the physician will not bill Medicare; and
- Medicare will not pay for the services nor is it likely that other insurance will pay.
- You have the right to receive services from Physicians and practitioners whose services are covered under Medicare and whose bills Medicare would pay.

> You should be aware that you may have substantial out-of-pocket expenses if you enter into a "private contract."

If you enter into a private contract with a health care provider who is not participating in Medicare and who is therefore prohibited from billing Medicare for services provided to Medicare beneficiaries, **the Plan will pay a maximum of 20% of the amount Medicare would have allowed if the provider were a Medicare participating provider.**

Please refer to the **Indemnity Medical Plan Exclusions** beginning on page 93.

Hearing Aid Coverage

The Plan pays 100% up to a maximum payment of $800 per ear (in any 3-year period) for the examination, hearing aid and all repairs or servicing. No benefits will be provided for:

- The replacement of a hearing aid for any reason more often than once during any 3-year period;
- batteries or any other ancillary equipment other than that obtained upon the purchase of the hearing aid; or
- expenses incurred for which the individual is not required to pay.

Submitting Claims

You must always **send your bills to Medicare first** for payment **before** submitting to the Fund.

To facilitate the Claims process if you include a "crossover" request to the Fund Office, Claims submitted to Medicare will be automatically forwarded to the Fund Office Claims department for processing of supplemental benefits. Your request for crossover must be in writing and include a copy of your Medicare identification card.

After you or your Doctor has received payment from Medicare, attach your Medicare Explanation of Benefits (EOB) and send the EOB and your itemized bills to the Anthem Blue Cross. Although Claims will be processed by the Fund Office, they should be mailed to Anthem Blue Cross who will electronically forward them to the Trust Fund.

Claims Address – Indemnity Medical Plan for Medicare Supplement Benefits

Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

BlueCard providers outside of California should send Claims to the local Blue Cross plan.

Vision Benefits

Copayments/Schedule of Benefits

You pay the Copayment regardless of whether you use a VSP Member Doctor or a non-VSP provider. The $10 exam Copayment is due only once each year, for the first service you receive each year (unless you qualify for the low vision benefit, which has different Copayments. See Section that describes "Low Vision Benefit" on page 86 for more information.)

Vision Benefits	VSP Member Doctor	Non-VSP Provider
Copayments for: • Exam • Materials (Prescription Glasses)	**You Pay** $10 $25	**You Pay** $10 $25
Vision Examination – Limited to once every 12 months	**Plan Pays** 100%, up to network provider contract rates	**Plan Pays** up to $40
Lenses – Limited to once every 12 months • Single Vision • Lined Bifocal • Lined Trifocal • Lenticular • Tints	**Plan Pays** 100%, up to network provider contract rates	**Plan Pays** up to: $40 $60 $80 $100 $ 5
Frames – Limited to once every 24 months	**Plan Pays** 100%, up to $175 retail allowance	**Plan Pays** up to $45
Necessary Contact Lenses – Limited to once every 12 months (in lieu of lenses and frames)	**Covered in Full** up to network provider contract rates	**Plan Pays** up to $210
Elective Contact Lenses – Limited to once every 12 months (in lieu of lenses and frames)	**Plan Pays** up to $155 for contact lenses and fitting and evaluation exam	**Plan Pays** up to $105 for exam and lenses
Costco frame allowance	$95	

Covered Vision Services

- Vision Examination – including analysis of visual functions and prescription of corrective eyewear when indicated, once every 12 months.
- Lenses – once every 12 months for regular every day wear lenses and once every 12 months for safety glasses.

- Frames – once every 24 months for regular every day wear frames and once every 24 months for safety glasses. VSP offers a selection of frames within Plan limits. If you choose more expensive frames (exceeding the Plan limit), you will be responsible for the additional amount over the Plan's maximum.
- Visually Necessary Contact Lenses – once every 12 months. Visually necessary contacts obtained from a VSP Member Doctor are covered in full. When they are obtained from a non-VSP provider, an allowance will be paid toward the cost. Contact lenses are visually necessary if they are needed to restore or maintain visual acuity and a less expensive professionally acceptable alternative is not available. (Visually necessary contact lenses are subject to the exam and materials Copayments.)

Contact lenses are provided in lieu of all other benefits for lenses and frames and only when a prescription change is warranted.

- Elective Contact Lenses – once every 12 months. If you choose contact lenses for any purposes other than the visually necessary circumstances described above, they are considered elective contact lenses. When you choose contact lenses instead of glasses, your $155 or $105 allowance applies to the cost of the contacts and the contact lens exam and fitting evaluation. This is in addition to your regular vision exam, which is covered in full (if from a VSP Member Doctor). When contact lenses are obtained, you will not be eligible for regular spectacle lenses again for 12 months and frames for 24 months. (Note: The exam and materials Copayments do not apply to elective contact lenses.)

Discounts From VSP Member Doctors

When you use a VSP Member Doctor, you will be entitled to discounts on charges for some non-covered items and contact lenses. These discounts include:

- 20% off for additional prescription glasses and sunglasses when a complete pair of glasses is dispensed within the last 12 months of your WellVision Exam.
- 30% average savings on the most popular lens options, such as scratch resistant and anti-reflective coatings and progressives.
- 15% discount off cost of contact lens exam (fitting and evaluation).

Exclusions and Limitations

When you select any of the following extra items, the Plan will pay the basic cost of the allowed lenses or frame, and you must pay any additional cost for the options, including:

- Optional cosmetic processes
- Anti-reflective coating
- Color coating, mirror coating or scratch coating
- Blended lenses
- Cosmetic lenses, laminated lenses, or oversize lenses
- Polycarbonate lenses (covered for Dependent children)
- Premium and custom progressive multifocal lenses
- UV (ultraviolet) protected lenses
- Certain limitations on low vision care

- A frame that costs more than the Plan allowance

Services Not Covered

There are no benefits payable for professional services or materials connected with:

- Orthoptics or vision training and any supplemental testing; plano lenses (less than a +/-.50 diopter power); or 2 pair of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this Plan that are lost or broken; except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Services that can be obtained without cost from any federal, state, county or local organization or agency.
- Corrective vision treatment of an Experimental nature.
- Costs for services and/or materials above Plan benefit allowances.

Low Vision Benefit

The Low Vision Benefit is available if you have severe visual problems that cannot be corrected with regular lenses. If you qualify for this benefit, you may receive professional services as well as ophthalmic materials, including supplemental testing, evaluations, visual training, low vision prescription services and optical and non-optical aids, subject to the maximums outlined in the following chart.

Low Vision Benefits	VSP Member Doctor	Non-Member Doctor
Supplemental testing	**Covered in full**	**Plan Pays** up to $125
Supplemental Aids	**Plan Pays** 75% of the approved cost	**Plan Pays** 75% of the approved cost
Maximum Benefit	**Plan Pays** $500 per person, every two (2) years	**Plan Pays** $500 per person, every two (2) years

How to File a Claim

If you use a non-VSP provider, call VSP at (800) 877-7195 to have an Out-of-Network Reimbursement Form mailed or faxed to you. (You can also fill out the form online at www.vsp.com and print it.) Mail the completed form with your itemized receipt to VSP at:

Vision Service Plan
Attn: Out-of-Network Provider Claims
P.O. Box 495918
Cincinnati, OH 45249-5918

When you use a VSP Member Doctor, you do not need to file a Claim for reimbursement.

Appeals for Denied Vision Care Benefits

If your Claim is denied, in whole or in part, you will receive written notification from VSP including the reasons for denial. If you do not agree with the denial you may then submit a written request to VSP for reconsideration within 180 days from the date you received the denial. Any request for reconsideration should include documents or records in support of your appeal. VSP will provide a written response to the appeal within 30 days after it is received.

Any request to VSP should be sent to the following address:

Vision Service Plan Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
(800) 877-7195

See the brochure from VSP and "Claims and Appeals Procedures" in this booklet.

Vision Plan benefits are treated as standalone (or excepted) benefits under the Health Insurance Portability and Accountability Act (HIPAA) and the Patient Protection and Affordable Care Act of 2010 (PPACA). Even though the Fund is not required to do so under PPACA, the Fund offers Vision Plan benefits for covered Dependents up to age 26.

Prescription Drug Benefits

The prescription Drug benefits described in this chapter are only for **Retirees and Dependents** who are **covered** under the Indemnity Medical Plan and are eligible for Medicare. These benefits **do not apply** to Kaiser members or participants who are covered under the Indemnity Medical Plan and not eligible for Medicare.

Benefit Overview

The pharmacy benefit is managed by the Plan's pharmacy benefit manager, Express Scripts. To access the best benefits possible under the Plan, you should use an Express Scripts Participating Pharmacy. You can locate a Participating Pharmacy by visiting the website, www.express-scripts.com or by calling (800) 311-2757.

Following is a summary of what you will pay for covered prescription Drugs across the different stages of your Medicare Part D benefit. You can fill your covered prescriptions at a network retail pharmacy or through the home delivery service.

Drug Benefit	You Pay			
Deductible Stage	**You Pay** a $360 yearly deductible			
Initial Coverage Stage	**Tier**	**Retail** **One-Month (31 day) Supply**	**Retail** **Three-Month (90-day) Supply**	**Home Delivery** **Three-Month (90-day) Supply**
	Tier 1: Generic Drugs	$10 Copayment	$30 Copayment	$20 Copayment
	Tier 2: Preferred Brand Drugs	$40 Copayment	$120 Copayment	$80 Copayment
	Tier 3: Non-Preferred Drugs	$60 Copayment	$180 Copayment	$120 Copayment
	Tier 4: Specialty Tier Drugs	25% Coinsurance	25% Coinsurance	25% Coinsurance
	You will stay in this stage until the total cost of your Drugs reaches $5,030. Once you reach this limit, you move on to the Coverage Gap stage.			

Drug Benefit	You Pay
• If your doctor prescribes less than a full month's supply of certain Drugs, you will pay a daily Cost-Sharing rate based on the actual number of days of the Drug that you receive. • You may receive up to a 90-day supply of certain maintenance Drugs (taken on a long-term basis) by mail through the Express Scripts pharmacy. There is no charge for standard shipping.	
• Not all Drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply. Please contact Express Scripts Medicare customer service for more information.	
Coverage Gap Stage	• Brand Drugs: You will pay 25% of the cost of covered Medicare Part D brand Drugs, plus a portion of the dispensing fee. • Generic Drugs: You will pay 25% of the Plan's costs for all covered generic Drugs. You will stay in the Coverage Gap stage until you pay $4,850. Once you reach this yearly out-of-pocket amount, you move to the Catastrophic Coverage stage.
Catastrophic Coverage Stage	After your yearly out-of-pocket Drug costs (what you and others pay on your behalf, including manufacturer discounts but excluding payments made by your Medicare prescription Drug Plan) reach $4,850, you will pay **the greater of 5% Coinsurance or:** • A $2.95 Copayment for covered generic drugs (including brand Drugs treated as generics) with a maximum not to exceed the standard Cost-Sharing amount during the Initial Coverage stage. • A $7.40 Copayment for all other covered Drugs, with a maximum not to exceed the standard Cost-Sharing amount during the Initial Coverage stage.

Long-Term Care (LTC) Pharmacy

If you reside in an LTC facility, you pay the same as at a network retail pharmacy. LTC pharmacies must dispense brand-name Drugs in amounts of 14 days or less at a time. They may also dispense less than a one month's supply of generic Drugs at a time. Contact your Plan if you have questions about Cost-Sharing or billing when less than a one-month supply is dispensed.

Out-of-Network Coverage

You must use Express Scripts Medicare network pharmacies to fill your prescriptions. Covered Medicare Part D Drugs are available at out-of-network pharmacies only in special circumstances, such as illness while traveling outside of the Plan's service area where there is no network pharmacy. You generally have to pay the full cost for Drugs received at an out-of-network pharmacy at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. Please contact Express Scripts Medicare Customer Service at the number listed in the **Quick Reference Chart** at the beginning of this document.

Important Plan Information

- The service area for the prescription Plan is all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands and American Samoa. You must live in one of these areas to participate in this Plan.
- You are eligible for this Plan if you are entitled to Medicare Part A and/or are enrolled in Medicare Part B, are a U.S. citizen or are lawfully present in the United States, and are eligible for benefits from Carpenters Health and Welfare Trust Fund for California.
- The amount you pay may differ depending on what type of pharmacy you use; for example, retail, home infusion, LTC or home delivery.

- To find a network pharmacy near you, visit our website at www.Express-Scripts.com.
- Your prescription Plan uses a Formulary – a list of covered Drugs. The amount you pay depends on the Drug's tier and on the coverage stage that you've reached. From time to time, a Drug may move to a different tier. If a Drug you are taking is going to move to a higher (or more expensive) tier, or if the change limits your ability to fill a prescription, Express Scripts will notify you before the change is made.
- Your Plan provides benefits for Medicare Part D covered Drugs only. This restricts what Drugs are covered. For example, Drugs used to treat erectile dysfunction (ED) are not covered.
- To access your Plan's list of covered Drugs, visit our website at www.Express-Scripts.com.
- The Plan may require you to first try one Drug to treat your condition before it will cover another Drug for that condition.
- Your healthcare provider must get prior authorization from Express Scripts Medicare for certain Drugs.
- If the actual cost of a Drug is less than the normal Cost-Sharing amount for that Drug, you will pay the actual cost, not the higher Cost-Sharing amount.
- If you request a Formulary exception for a Drug and Express Scripts Medicare approves the exception, you will pay the Cost-Sharing amount set by the Plan for that Drug.
- You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party.

Read the *Medicare & You* handbook.

The *Medicare & You* handbook has a summary of Original Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. You can get a copy at the Medicare website (http://www.medicare.gov) or by calling 1.800.MEDICARE (800) 633-4227, 24 hours a day, 7 days a week. TTY users should call (877) 486-2048.

For a complete explanation of your Plan benefits, contact Express Scripts Medicare Customer Service at (800) 311-2757 or check your *Evidence of Coverage (EOC) by visiting the Express Scripts website, express-scripts.com/documents.* You can request a copy of the EOC by calling Express Scripts Medicare Customer Service at (800) 311-2757.

Does my Plan cover Medicare Part B or Non-Part D Drugs?

Express Scripts Medicare does not cover Drugs that are covered under Medicare Part B as prescribed and dispensed, or any other non–Part D Drugs. Generally, the pharmacy benefit covers Drugs, vaccines, biological products and medical supplies associated with the delivery of insulin that are covered under the Medicare prescription Drug benefit (Part D) and that are on the Formulary. The medical portion of the Carpenters Health and Welfare Plan will generally cover Drugs covered under Medicare Part B.

The Formulary and/or pharmacy network may change at any time. You will receive notice when applicable to your prescriptions.

Schedule of Indemnity Medical Plan Benefits for Retirees With Medicare

Category	What's Covered?	Medicare (Part A & B)	Indemnity Plan (includes Medicare Part D)	You Pay
Medical Benefits				
Annual Medical Deductible	Deductible for all medical coverage, including Medicare Plan A, Plan B and Indemnity Plan			**You Pay** $128 per individual, per year
Monthly Cost (premium)	Your monthly cost for medical coverage			**You Pay** Medicare Part B: $174.70 per individual* AND Indemnity Plan**: $193 Retiree only $377 Retiree + 1 Medicare-eligible Dependent $859 Retiree + 1 Non-M.E. Dependent $386 Surviving Spouse
Doctor Visits	Includes: - Services from doctors and health care providers - Outpatient care - Some home Health Care - Durable Medical Equipment - Preventive Services	**Medicare Pays** 80%	**Plan Pays** 20%	**You Pay** Zero
Hospital Stays	Includes: - Inpatient care in hospitals - Skilled Nursing Facility care - Hospice care - Some home health care	**Medicare Pays** Costs above Copayments (after Deductible) until maximums reached	**Plan Pays** $1,632 Deductible	**You Pay** (All below Per Benefit Period)*** Hospital Stay: $0 – Days 1-60 $408/day – Days 61-90 $816/day – 60 Lifetime Reserve Days Skilled Nursing Facility (SNF): $0 Days 1-20 $200/day – Days 21-100 Long-Term Care Hospitals: Same as Hospital Stays, but deductible waived if combined with Hospital/SNF stay
Supplemental Medical Benefits	Includes: - Mental health & substance abuse treatment - Hearing Aids	**Medicare Pays** 80%	**Plan Pays** 20%	**You Pay** Zero

Category	What's Covered?	Medicare (Part A & B)	Indemnity Plan (includes Medicare Part D)	You Pay
Vision Benefits				
Vision Benefit Includes: - Exam - Lenses - Frames - Necessary Contact Lenses - Elective Contact Lenses			**Plan Pays** 100% up to network provider contract rates - Frames up to $175 - Elective Contact Lenses up to $155 for lenses, fitting and exam	**You Pay** $10 Exam $25 Materials (prescription glasses) Any amounts over Plan limits
Prescription Drug Benefits				
Deductible Stage				**You Pay** $360 per individual, per year
Initial Coverage Stage (up to $5,030 total Drug cost)			**Plan Pays** Prescription costs above Copayments/ Coinsurance	**You Pay** Tier 1: Generic Drugs $10 - 1 Month Supply Retail $30 -3 Month Supply Retail $20 - 3 Month Supply Home Delivery Tier 2: Preferred Brand $40 Retail 1 Month Supply $120 Retail 3 Month Supply $80 Home Delivery 3 Month Supply Tier 3: Non-Preferred Drugs $60 Retail 1 Month Supply $180 Retail 3 Month Supply $120 Home Delivery 3 Month Supply Tier 4: Specialty Tier Drugs 25% Retail 1 Month Supply 25% Retail 3 Month Supply 25% Home Deliver 3 Month Supply
Coverage Gap Stage (until you pay $4,850)			**Plan Pays** 75% of total cost	**You Pay** Generic Drugs 25% Brand Drugs 25% + % of dispensing fee
Catastrophic Coverage Stage (when you pay > $4,850)			**Plan/Medicare Pays** Prescription costs above Copayments/ Coinsurance	**You Pay** > of 5% OR $2.95 generic Drugs $7.40 all other Drugs $7.40 All Other Drugs

**Monthly Part B rate is higher if your annual income is over limit established by CMS ($103,000 in 2024)*

***Additional cost for more than 1 Dependent*

****Benefit period starts when you are admitted as an inpatient and ends when you have not received any inpatient care for 60 consecutive days*

Note: This chart is only an overview. Limitations and Exclusions apply. Please see sections below for details and explanations.

Section 4 –Indemnity Medical Plan Exclusions and Limitations For Retirees With Medicare and Without Medicare

This section includes:

- Indemnity Plan Exclusions and Limitations.
- A section on How to File Claims including what you need to do to file an appeal if a Claim is denied.
- Rules regarding Coordination of Benefits (COB) and Third Party Liability.
- Information required by the Employee Retirement Income Security Act of 1974 (ERISA)

Indemnity Medical Plan Exclusions

No benefits are payable for the following:

1. Any amounts in excess of Allowed Charges for Non-Contract Providers or the contract rate for Contract Providers.
2. Expenses for which benefits are payable under any other programs provided by the Fund.
3. Any expense incurred for services furnished or supplies purchased prior to the date you or your Dependents became eligible. An expense is considered incurred on the date the person receives the service for which the charge is made.
4. Custodial Care or rest cures. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. The Plan may cover a stay at a long-term acute care facility when a patient is receiving rehabilitation therapy immediately after or instead of an acute inpatient hospitalization. For the Plan to consider such services, the stay must receive prior authorization and the patient must continue to make treatment progress as documented by patient notes.
5. Services received while an Eligible Individual is confined in a Hospital operated by the United States Government or an agency of the United States Government. The Plan, to the extent required by law, will reimburse a VA Hospital for care of a non-service-related disability if the Plan would normally cover the care were the Department of Veterans Affairs were not involved.
6. Any work-related Injury or Illness. However, the Plan will pay benefits on behalf of an Eligible Individual who has incurred an occupational Injury or Illness subject to the following conditions:
   a. The Eligible Individual signs an agreement to diligently prosecute his or her Claim for Workers' Compensation benefits or for any other available occupational compensation benefits; and
   b. the Eligible Individual agrees to reimburse the Fund for any benefits paid by the Fund by consenting to a lien against any occupational compensation benefits received through adjudication, settlement or otherwise; and
   c. the Eligible Individual cooperates with the Fund or its designated representative by taking reasonably necessary steps to obtain reimbursement, through legal action or otherwise, for any benefits paid for the Eligible Individual's occupational Injury or Illness.
7. Conditions resulting from act of war or armed invasion.
8. Treatment on or to the teeth, or gums (other than for tumors), except as provided for dental injury, including: Extraction of teeth; treatment of dental abscess or granuloma; dental plates, bridges, crowns, caps or other dental prosthesis. You may choose to enroll in a separate dental plan offered by Delta Dental for Retirees.
9. Eyeglasses, contact lenses, routine eye examinations, eye refractions for the fitting of glasses, vision therapy including orthoptics, or any refractive eye surgery.
10. Routine newborn nursery charges billed by a Non-Contract Hospital.
11. Cosmetic services, except for conditions resulting from an accident or a functional disorder or reconstructive surgery following a mastectomy.
12. Any expense incurred for services or supplies that constitute personal comfort or beautification items, or for weight loss programs.

13. Drugs, except while the patient is hospitalized and entitled to receive Hospital benefits. (See also information on prescription Drug benefits for individuals enrolled in the Indemnity Medical Plan.)
14. Hospital admissions primarily for custodial care.
15. Services of a naturopath or any other provider not meeting the definition of Physician, except as may be provided under specific benefits of the Plan.
16. Services not specifically listed as covered services, or those services that are not Medically Necessary or not considered as common medical practice by the Plan.
17. Services for which the Eligible Individual is not legally obligated to pay or for which no charge is made to the Eligible Individual. Services for which no charge is made to the Eligible Individual in the absence of insurance coverage, except services received at a non-government charitable research hospital.
18. Professional services received from a registered nurse or physical therapist who lives in the Eligible Individual's home or who is related to the Eligible Individual by blood or marriage.
19. Inpatient Hospital charges in connection with a Hospital stay primarily for physical therapy.
20. Educational services, supplies or equipment, including, but not limited to computers, computer devices/software, printers, books, tutoring or interpreters, visual aids, vision therapy, auditory or speech aids/synthesizers, auxiliary aids such as communication boards, listening systems, device/programs/services for behavioral training including intensive intervention programs for behavior change and/or developmental delays or auditory perception or listening/learning skills (except for therapy that is being done as part of an approved autism plan), programs/services to remedy or enhance concentration, memory, motivation, reading or self-esteem, etc., special education and associated costs in conjunction with sign language education for a patient or family members, and implantable medical identification/tracking devices.
21. Orthopedic shoes (except when joined to braces) or shoe inserts (except custom-made orthotics), air purifiers, air conditioners, humidifiers, exercise equipment for conditioning (e.g., Nautilus Equipment, etc.), or supplies for comfort, hygiene or beautification.
22. Educational services, nutritional counseling or food supplements except for benefits provided for Diabetic Instruction programs or nutritional counseling services that are medically necessary for the treatment of an individual diagnosed with a mental health condition, such as an eating disorder. Coverage is provided and payable according to the Plan benefits that apply to that specific service. In addition, this exclusion does not apply to Total Parenteral Nutrition (TPN) that is approved by Anthem as Medically Necessary and curative in nature. Not all charges are eligible for benefits. For example, services that are not medically necessary, nutritional counseling that is not for treatment of a mental health condition, and/or nutritional counseling that is not part of an otherwise covered Diabetes Instruction Program are excluded.
23. Physical therapy services that are primarily educational, sports-related or preventive, such as physical conditioning, exercise or back school.
24. Speech therapy, occupational therapy (except rehabilitation treatment following an Illness or Injury or if the therapy is being done as part of an approved autism plan).
25. Infertility treatment along with services to induce pregnancy and complications resulting from those services, including, but not limited to: services, prescription Drugs, procedures or devices to achieve fertility, in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor egg/semen or other fees, cryostorage of

egg/sperm, adoption, ovarian transplant, infertility donor expenses, fetal implants, fetal reduction services, surgical impregnation procedures and reversal of sterilization.

26. Hypnotism, biofeedback, stress management, and any goal-oriented behavior modification, such as to lose weight or to control pain.
27. Non-surgical services primarily for weight loss.
28. Claims submitted more than 12 months from the date of service.
29. Any services and supplies in connection with Experimental or Investigational Procedures.
30. Any services and supplies in connection with an Illness, Injury, disease or other condition for which a third party (or parties) may be liable or legally responsible by reason of an act, omission, or insurance coverage of that third party or parties (referred to in this SPD collectively as “responsible third party”).
31. Reimbursement for percentage of the amount that would have been payable in accordance with Medicare allowable payments for expenses from Non-Contract Hospital, Non-Contract Facility and other Non-Contract providers who did not complete enrollment in the Medicare program or did not submit an affidavit to Medicare expressing their decision to opt-out of the Medicare program.
32. Habilitative services are not covered (except for therapy that is being done as part of an approved autism plan).
33. Charges from providers who, following an investigation and recommendation by the Plan’s fraud, waste and abuse vendor, who have been determined to have engaged in fraudulent activity.

Claims and Appeals Procedures

There are various types of Claims associated with Plan benefits, procedures for filing Claims, and procedures for you to follow if your Claim is denied in whole or in part and you wish to appeal the decision. Throughout this section, “you” and “your” may refer to you, your Dependent(s) and/or your authorized representative, as applicable.

Use of Authorized Representative

An authorized representative, such as your Spouse or an adult child, may submit a Claim or appeal on your behalf if you have previously designated the individual to act on your behalf through a form available from the Fund Office. The Fund Office may request additional information to verify that the designated person is authorized to act on your behalf.

A health care professional with knowledge of your medical condition may act as an authorized representative in connection with the “Urgent Claims” discussed below without your having to designate an authorized representative.

Types of Claims

There are different types of Claims applicable to the benefits listed at the start of this section. Four of them have to do with health care:

For information about where to submit a Claim or file an appeal, please refer to the chart on page 110 of this document.

1) **Pre-Service Claims**: A Pre-Service Claim is a request for authorization of care or treatment that requires approval in whole or in part before the care or treatment is obtained called Utilization Review (“pre-authorization” or “pre-certification”).

Under this Plan, Retirees and Dependents who are not eligible for Medicare are required to receive **Utilization Review** for the following services:

- Non-Emergency Hospital admissions (including mental health and substance abuse), other than stays of a certain length following childbirth or admissions when the Plan is the secondary payer (must be pre-approved by Anthem Blue Cross).
- Certain outpatient procedures such as Colonoscopy, Arthroscopy, Cataract Surgery, Endoscopies, Laparoscopic gall bladder removal, Hysteroscopy uterine tissue sample (with biopsy, with or without dilation and curettage), Nasal/Sinus - submucous resection inferior turbinate services, Tonsillectomy and/or adenoidectomy (for a Member under age 12), Nasal/sinus corrective surgery – septoplasty, Lithotripsy, Hernia inguinal repair (over age 5, non-laparoscopic), Esophagoscopy, Repair of laparoscopic inguinal hernia, Sigmoidoscopy, Upper gastrointestinal endoscopy without biopsy, Upper gastrointestinal endoscopy with biopsy, Single knee replacement, Single hip replacement (must be pre-approved by Anthem Blue Cross).
- Organ transplants (must be pre-approved by Anthem Blue Cross).
- Certain prescription Drugs (must be approved by the Plan’s pharmacy benefit manager). Call Express Scripts at (800) 939-7093 for a list of the Drugs that require prior approval.
- Certain outpatient diagnostic imaging services including: CT/CTA, MR/MRI, Nuclear cardiology, PET scan and echocardiography (must be pre-approved by Anthem Blue Cross).

If you fail to get prior approval for these services, your benefits may be denied.

2) **Urgent care Claims:** Your request for a required pre-authorization will be considered an Urgent Claim if applying the time frames allowed for a Pre-Service Claim (*generally **15 days** for a request submitted with sufficient information*) would:

- Seriously jeopardize your life or health or your ability to regain maximum function; or
- in the opinion of a Physician with knowledge of your medical condition, subject you to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

The claims evaluator, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, will determine whether your Claim is an Urgent Claim. Alternatively, if a Physician with knowledge of your medical condition determines your Claim is an Urgent Claim and notifies the claims evaluator, it will be treated as an Urgent Claim.

3) **Concurrent Claims:** A Concurrent Claim is a decision that is reconsidered after an initial approval was made, resulting in a reduction, termination, or extension of the previously approved benefit. (For example, an inpatient hospital stay originally pre-approved for 5 days is subjected to concurrent review at 3 days to determine if the full 5 days are appropriate.) In this situation, a decision to reduce, terminate, or extend treatment is made concurrently with the provision of treatment. This category also includes requests by you or your provider to extend care or treatment approved under an Urgent Claim.

4) **Post-Service Claims:** Any other type of health care Claim is considered a Post-Service Claim—for example, a Claim submitted for payment after health services and treatment have been obtained.

What is Not a "Claim"

The following are not considered claims and are thus not subject to the requirements and time frames described in this section:

- Casual inquiries about benefits or the circumstances under which benefits might be paid.
- A request for an advance determination regarding the Plan's coverage of a treatment or service that does not require Utilization Review.
- A prescription you present to a pharmacy to be filled. However, if you are required to pay the full cost to have your prescription filled, you should submit a Post-Service Claim for the applicable reimbursement.

Filing a Claim

The method used to file a Claim will depend on the type of Claim.

Pre-Service Claims (for Retirees and Dependents not eligible for Medicare):

- **Pre-Service Claims under the Indemnity Medical Plan:** Have your Physician call Anthem Blue Cross at (800) 274-7767 to request Utilization Review.
- **Pre-Service Claims for prescription Drug benefits:** Have your Physician call Express Scripts (the Plan's pharmacy benefit manager) at (800) 939-7093 to obtain pre-authorization for any Drug requiring Utilization Review.

Urgent Claims: Urgent Claims (Claims for Utilization Review that need to be handled on an expedited basis) should be directed to the same parties mentioned above for Pre-Service Claims. **Urgent Claims**

must be submitted by telephone, in person, **or by secure email** to: BCCUMintake@wellpoint.com. Urgent Claims may not be submitted via the U.S. Postal Service.

Post-Service Claims: Claim forms for Post-Service health care Claims must be completed in full, and an itemized bill or bills must be attached.

Indemnity Medical Claims (including mental health and chemical dependency) should be sent to: Anthem Blue Cross, P.O. Box 60007, Los Angeles, CA 90060-0007. Contract providers will submit your Claims for you. (Blue Card providers outside of California should send Claims to the local Blue Cross plan.)

Hearing aid Claims should be sent to the Fund Office at the following address: Carpenters Health and Welfare Trust Fund for California, 265 Hegenberger Road, Suite 100, Oakland, CA 94621-1480.

Claims for prescription Drug benefits: To file a Claim for reimbursement if you live more than 10 miles from a network pharmacy and have used a non-network pharmacy, if you forgot your Plan identification card and had to pay the full price at a network pharmacy, or for coordination of benefits Claims if this Plan is secondary: Send your Claim directly to Express Scripts, P.O. Box 14711, Lexington, Kentucky 40512. You can call Express Scripts customer service for a Claim form.

Claims for vision care benefits (a Claim for reimbursement if you use a provider that does not participate in the VSP network): Send directly to VSP at the following address: Vision Service Plan, Attn: Out-of-Network Provider Claims, P.O. Box 997105, Sacramento, CA 95899-7105.

When Claims Must Be Filed

Your Claim will be considered to have been filed as soon as it is received by the applicable Claims evaluator mentioned under "**Filing a Claim**."

- Pre-Service and Urgent Claims must be approved before services are obtained.
- You must submit all other health care Claims within 90 days of when expenses are incurred, unless it is not reasonably possible to do so. In no event will Claims be paid if they are submitted more than 1 year after the date the charges were incurred. The Claim form must be completed in full, and an itemized bill or bills must be attached.

Notification That Your Pre-Service or Urgent Claim Has Not Been Properly Filed

- If your Pre-Service Claim has been improperly filed, you will be notified as soon as possible but no later than 5 days after receipt of the Claim of the proper procedures to be followed in filing a Claim.
- If your Urgent Claim has been improperly filed, you will be notified as soon as possible but no later than 24 hours after receipt of the Claim of the proper procedures to be followed in filing a Claim.

You will receive notice that you have improperly filed your Claim only if the Claim includes your name, your specific condition or symptom, and a specific treatment, service, or product for which approval is requested. Unless the Claim is re-filed properly, it will not constitute a Claim.

Timing of Initial Claims Decisions

A determination on your Claim will be made within the following time frames:

Pre-Service Claims: If your Pre-Service health care Claim has been properly filed, you will normally be notified of a decision within **15 days** from the date your Claim is filed, unless additional time is needed as described below.

- The time for response may be extended by up to 15 days if necessary due to matters beyond the control of the applicable Claims evaluator. If an extension is necessary, you will be notified before the end of the initial 15-day period of the circumstances requiring the extension and the date by which the Claims evaluator expects to make a decision.
- If an extension is needed because the Claims evaluator needs additional information from you, the Claims evaluator will notify you as soon as possible, but no later than 15 days after receipt of the Claim, of the specific information necessary to complete the Claim. In that case you and/or your doctor will have 45 days from receipt of the notification to respond. During the period in which you are allowed to supply additional information, the normal period for making a decision on the Claim will be suspended. The deadline is suspended from the date of the extension notice until either the 45 days have passed or you respond to the request (whichever is earlier). The Claims evaluator then has 15 days to make a decision and notify you of the determination. If the information is not provided within the 45 days allowed, your Claim will be denied.

Urgent Claims: You will be notified of a determination by telephone as soon as possible, taking into account the circumstances of your situation, but no later than **72 hours** after receipt of the Claim by the Claims evaluator. The determination will also be confirmed in writing.

- If your Urgent Claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, the Claims evaluator will notify you as soon as possible, but no later than **24 hours** after receipt of the Claim, of the specific information necessary to complete the Claim. You and/or your doctor must respond to this request within **2 business days**. During the period in which you are allowed to supply additional information, the normal period for making a decision on the Claim will be suspended. The deadline is suspended from the date of the extension notice until either the **2 business days** have passed or you respond to the request (whichever is earlier). Notice of a decision will be provided no later than **48 hours** after the receipt of the required information. If the information is not provided within the **2 business days** allowed, your Claim will be denied.

Concurrent Claims: A reconsideration that involves the termination or reduction of payment for a treatment in progress (other than by Plan amendment or termination) will be made by the Claims evaluator as soon as possible, but in any event early enough to allow you to have an appeal decided before the benefit is reduced or terminated.

A request by you to extend treatment approved under an Urgent Claim will be acted upon by the Claims evaluator within **24 hours** of receipt of the Claim, provided the Claim is received at least **24 hours** prior to the expiration of the approved treatment.

Post-Service Claims: Ordinarily, you will be notified of the decision on your Post-Service health care Claim within **30 days** of the date the Claims evaluator receives the Claim. This period may be extended one time by up to **15 days** if the extension is necessary due to matters beyond the control of the Claims evaluator. If an extension is necessary, you will be notified before the end of the initial **30-day** period of

the circumstances requiring the extension and the date by which the Claims evaluator expects to make a decision.

If an extension is needed because the Claims evaluator needs additional information from you, the Claims evaluator will notify you as soon as possible, but no later than **30 days** after receipt of the Claim, of the specific information necessary to complete the Claim. You and/or your doctor or dentist will have **45 days** from receipt of the notification to respond. During the period in which you are allowed to supply additional information, the normal period for making a decision on the Claim will be suspended. The deadline is suspended from the date of the extension notice until either **45 days** have passed or the date you respond to the request (whichever is earlier). The Claims evaluator then has **15 days** to make a decision on your Post-Service Claim and notify you of the determination. If the information is not provided within the **45 days** allowed, your Claim will be denied.

Emergency Services, Non-Emergency Services at PPO Facilities by Non-PPO Providers, and Air Ambulance: The Plan will make an initial payment or notice of denial of payment for Emergency Services, non-Emergency Services at Services at Contract Facilities by Non-Contract Providers, and air ambulance services within **30 calendar days** of receiving a clean Claim from the Non-Contract Provider. The **30-day** calendar period begins on the date the Plan receives the information necessary to decide a Claim for payment for the services.

If a Claim is subject to the No Surprises Act, the Participant cannot be required to pay more than the Cost-Sharing under the Plan, and the provider or facility is prohibited from billing the Participant or Dependent in excess of the required cost sharing.

If a Non-Contract Provider or facility and the Plan enter into the Independent Dispute Resolution (IDR) process under the Federal No Surprises Act (Public Law 116-260, Division BB) and do not agree before the date on which a certified IDR entity makes a determination with respect to such item or service, the allowable amount is the amount of such determination. The Participant or Dependent has no right nor obligation to participate in any IDR process under the Federal No Surprises Act

Denied Claims (Adverse Benefit Determinations)

An "Adverse Benefit Determination" is any denial, reduction, termination of or failure to provide or make payment for a benefit (either in whole or in part) under the Plan. Each of the following is an example of an Adverse Benefit Determination:

- A payment of less than 100% of a Claim for benefits;
- a denial, reduction, termination of or failure to provide or make payment for a benefit (in whole or in part) resulting from any decision on a required Utilization Review or concurrent Utilization Review;
- a failure to cover an item or service because the Fund considers it to be experimental, investigational, not Medically Necessary or not medically appropriate;
- a decision that denies a benefit based on a determination that you or a Dependent is not eligible to participate in the Plan.

You will be provided with written notice of the initial benefit determination. If it is an Adverse Benefit Determination, the notice may include the following:

- The specific reason(s) for the determination;
- reference to the specific Plan provision(s) on which the determination is based;

- a description of any additional material or information needed to perfect your Claim and an explanation of why the material or information is needed;
- a description of the appeals procedures and applicable time limits;
- a statement of your right to bring a civil action under ERISA Section 502(a) following the appeal of an Adverse Benefit Determination;
- if an internal rule, guideline or protocol was relied upon in deciding the Claim, a statement that a copy is available upon written request at no charge; and
- if the determination was based on the absence of medical necessity, or the treatment's being experimental or investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon written request at no charge.

For Urgent Claims, the notice will describe the expedited review process applicable to Urgent Claims. For Urgent Claims, the notice may be provided orally and followed with written notification.

Appealing an Adverse Benefit Determination

If your Claim is denied or you disagree with the amount of the benefit, you may ask for a review (appeal the decision) as described below.

For guidance on Appealing an Adverse Benefit Determination, please refer to "**Denied Claims**" beginning on page 101 and to the chart on page 110 of this document.

You must submit your appeal by the applicable deadline within **180 days** after you receive the notice of denial for a Claim involving health care or disability (or, in the case of a Concurrent Claim, within a reasonable time, given the circumstances of your situation).

All appeals must state the reason you are disputing the denial and be accompanied by any pertinent material not already furnished. How and where you will submit your appeal depends on what type of Claim it is:

- **Pre-Service Claims:** Appeals of Pre-Service Claim denials must be in writing via mail. Those involving Indemnity Medical Plan benefits should be sent to Anthem Blue Cross. Those involving prescription drug benefits should go to the pharmacy benefit manager (Express Scripts).
- **Urgent Claims:** Appeals of Urgent Claim denials must be made either by telephone or by a similarly expeditious method. Appeals of Urgent Claims may **not** be submitted via the U.S. Postal Service.

Appeals of Urgent Claim denials should be sent to the applicable review authority mentioned in "Pre-Service Claims" immediately above.

- **Concurrent Claims:** Appeals of Adverse Benefit Determinations regarding Concurrent Claims must be made in the same manner described for Urgent Claims.
- **Post-Service Claims:** Appeals of Post-Service Claim denials must be submitted in writing to the Fund Office.

Failure to follow the proper procedures or to file an appeal within the prescribed period will constitute a waiver of your right to a review of the denial of your Claim.

Review Process

The review process works as follows:

- You will be given the opportunity to submit written comments, documents, and other information for consideration during the appeal, even if such information was not submitted or considered as part of the initial benefit determination.
- You will be provided, upon written request and free of charge, reasonable access to and copies of all Relevant Documents pertaining to your Claim. A document is relevant if it was relied upon in making the benefit determination; it was submitted, considered, or generated in the course of making the benefit determination; it demonstrates compliance with the Plan's administrative processes and safeguards required by the regulations; or it constitutes the Fund's policy or guidance with respect to the denied treatment option or benefit. Relevant Documents could include specific Fund rules, protocols, criteria, rate tables, fee schedules or checklists and administrative procedures that prove the Fund's rules were appropriately applied to a Claim.
- The appeal will be reviewed by someone other than the person who originally made the initial Adverse Benefit Determination on the Claim. The reviewer will not give deference to the initial Adverse Benefit Determination. The decision will be made on the basis of the record, including additional documents and comments that may be submitted by you.
- The Board may grant a personal hearing to receive and hear any evidence or argument you believe cannot be presented satisfactorily by correspondence.
- If the Claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice on the Claim, without regard to whether the advice was relied upon in deciding the Claim. Any health care professional engaged for the purpose of a consultation may not be an individual or any subordinate of such individual who was consulted in connection with the initial determination that is the subject of the appeal.

Notice of Decision on Appeal

You will receive notice of the decision made on your appeal according to the following timetable:

- **Pre-Service Claims:** A notice of a decision on review will be sent within **30 days** of receipt of the appeal.
- **Urgent Claims:** A notice of a decision on review will be sent within **72 hours** of receipt of the appeal.
- **Concurrent Claims:** Notice of the appeal determination for a Concurrent Claim will be sent prior to the termination of the benefit.
- **Post-Service health care Claims:** Ordinarily, decisions on appeals will be made **at the next regularly scheduled meeting** of the Board of Trustees following receipt of your request for review. However, if your request for review is received less than **30 days** before the next regularly scheduled meeting, it may be considered at the second regularly scheduled meeting following receipt. In special circumstances, an extension until the third regularly scheduled meeting following receipt of your request for review may be necessary. If such an extension is necessary, you will be advised in writing of the special circumstances and the date by which a decision will

be made before the extension begins. Once a decision has been reached, you will be notified as soon as possible, but no later than **5 days** after the date of the decision.

If Your Appeal is Denied

The determination of an appeal will be provided to you in writing. The notice of a denial of an appeal will include the following:

- The specific reason(s) for the determination;
- reference to the specific Plan provision(s) on which the determination is based;
- a statement that you are entitled to receive reasonable access to and copies of all documents relevant to the Claim, upon written request and free of charge;
- a statement of your right to bring a civil action under ERISA Section 502(a) following an Adverse Benefit Determination on appeal;
- if an internal rule, guideline or protocol was relied upon, a statement that a copy is available upon written request at no charge; and
- if the determination was based on medical necessity, the treatment's being experimental or investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon written request at no charge.

For any Claims asserted under the Plan or against the Fund or the denial of a Claim to which the right to review has been waived, the decision of the Board or its designated Appeals Committee with respect to a petition for review is final and binding upon all parties, subject only to any civil action you may bring under ERISA. No legal action may be started or maintained more than 2 years after the date you have been notified in writing that the Claim has been deemed denied. Following issuance of the written decision of the Board on an appeal, there is no further right of appeal to the Board or right to arbitration with the exception of Claims covered under the No Surprises Act.

Claims Covered under the No Surprises Act

External Review of certain Claims for Emergency Services, Non-Emergency Services from Non-Contract provider at a Contract facility, and Air Ambulance services.

The Board has established a voluntary external review process to comply with the No Surprises Act external review requirements. External review is only applicable in certain cases. Your provider of service may seek further external review, by an Independent Review Organization ("IRO"), only in the situation where the appeal of a health care Claim (Urgent, Concurrent, Pre-Service or Post-Service) is denied and is a Claim for Emergency Services, non-Emergency Services from a Non-Contract Provider at a Contract Facility, or air ambulance.

Generally, you may only request external review after you have exhausted the Plan's internal Claims and appeals process described above. This means that, generally, you may only seek external review after a final determination has been made on an appeal.

External review is not available for any other types of denials, including if a Claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan.

There is no cost to you to request an external review. The Plan assumes responsibility for fees associated with external reviews outlined in this document.

External Review of Standard (Non-Urgent) Claims

You may request external review of a standard (not urgent) Claim in writing, within **4 months** of the date that a notice of a Claim Appeal Benefit Determination is received. For convenience, these determinations are referred to below as an "Adverse Determination."

Preliminary Review of Standard Claims. Within **5 business days** of the Plan's receipt of your request for external review of a standard Claim, the Plan will complete a preliminary review of the request to determine whether:

- You were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
- The Adverse Determination satisfies the requirements for external review;
- You have exhausted the Plan's internal Claims and appeals process (except, in limited, exceptional circumstances when under the regulations you are not required to do so); and
- You have provided all of the information and forms required to process an external review.

Within **1 business day** of completing its preliminary review, the Plan will notify you in writing as to whether the request for external review meets the above requirements. This notification will inform you:

- If the request is complete and eligible for external review; or
- If the request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).
- If the request is not complete (incomplete), the notice will describe the information or materials needed to complete the request, and allow you to perfect (complete) the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

Review of Standard Claims by an Independent Review Organization (IRO): If the request is complete and eligible for external review, the Plan will assign the request to an IRO. Once the Claim is assigned to an IRO, the following procedure will apply:

- The assigned IRO will notify you in writing in a timely manner of the request's eligibility and acceptance for external review, including directions about how to submit additional information regarding the Claim (generally, you are allowed to submit such information within **10 business days**).
- Within **5 business days** after the external review is assigned to the IRO, the Plan will provide the IRO with the documents and information the Plan considered in making its Adverse Determination.
- If you submit additional information related to the Claim to the IRO, the assigned IRO must, within **1 business day**, forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its Adverse Determination, the Plan will provide written notice of its decision to you and the IRO within **1 business day** after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

- The IRO will review all of the information and documents received in established time frames. In reaching a decision, the IRO will review the Claim *de novo* (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal Claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.
- In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, recommendations or other information from your treating (attending) health care providers, other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).
- The assigned IRO will provide written notice of its final external review decision to you and the Plan **within 45 days** after the IRO receives the request for external review.
- If the IRO's final external review reverses or modifies the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal or modification, the Plan will immediately provide coverage or payment for the reviewed Claim. However, even after providing coverage or payment for the Claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.
- If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed Claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

The assigned IRO's decision notice will include:

- A general description of the reason for the request for external review, including information sufficient to identify the Claim (including the date or dates of service, health care provider, Claim amount (if applicable), diagnosis code and its corresponding meaning, and treatment code and its corresponding meaning, and reason for the previous denial);
- the date that the IRO received the request to conduct the external review and the date of the IRO decision;
- references to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;
- a discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;
- a statement that the IRO's determination is binding on the Plan (unless other remedies may be available to you or the Plan under applicable State or Federal law);
- a statement that judicial review may be available to you; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

External Review of Expedited Urgent Care Claims

You may request an expedited external review if:

- You receive an adverse Initial Claim Appeal Benefit Determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize life or health, or would jeopardize the ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
- You receive an adverse Appeal Claim Benefit Determination that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize the ability to regain maximum function; or, you receive an adverse Claim Appeal Benefit Determination that concerns an admission, availability of care, continued stay, or health care item or service for which you received Emergency Services, but you have not yet been discharged from a facility.

Preliminary Review for an Expedited Claim*.* Immediately upon receipt of the request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for Expedited Review are met (as described under Standard Claims above). The Plan will immediately notify you (e.g., telephonically, via fax) as to whether the request for review meets the preliminary review requirements, and if not, will provide or seek the information (also described under Standard Claims above).

Review of Expedited Claim by an Independent Review Organization (IRO)*.* Following the preliminary review that a request is eligible for expedited external review, the Plan will assign an IRO (following the process described under Standard Review above). The Plan will expeditiously (e.g. meaning via telephone, fax, courier, overnight delivery, etc.) provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

- In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, recommendations or other information from your treating (attending) health care providers, other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).
- The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review, (described above under Standard Claims). In reaching a decision, the assigned IRO must review the Claim de novo (as if it is new) and is not bound by any decisions or conclusions reached during the Plan's internal Claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law.
- The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.
- The IRO will provide notice of their final expedited external review decision, in accordance with the requirements set forth above under Standard Claims, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice of the IRO's decision is not in writing,

within 48 hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

- If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed Claim. However, even after providing coverage or payment for the Claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed Claim. If the claimant is dissatisfied with the external review determination, they may seek judicial review as permitted under ERISA Section 502(a).

When a Lawsuit May Be Started

If you believe the rules of the Plan were not applied appropriately in the decision made on your appeal, you may file a lawsuit in Federal court against the Plan. However, no legal or equitable action for benefits under this Plan shall be brought unless and until you have:

- Submitted a Claim for benefits pursuant to the Plan's Rules and Regulations;
- been notified that the Claim is denied (or the Claim is deemed denied);
- requested a review of the Adverse Benefit Determination and exhausted all administrative procedures, including all Claim appeal and review procedures for every issue you deem relevant; and
- been notified in writing that the denial of the Claim has been confirmed (or the Claim is deemed denied) on review.

("Deemed denied" means that you filed a Claim or an appeal and had not received a decision or notice that an extension would be necessary by the expiration of the response time allowed for the type of Claim.)

No legal action may be started or maintained more than 2 years after the date you have been notified in writing that the Claim has been deemed denied.

Waiver of Class, Collective and Representative Actions

By participating in the Plan, to the fullest extent permitted by law, whether in court, Participants waive any right to commence, be a party to in any way, or be an actual or putative class member of any class, collective, or representative action arising out of or relating to any dispute, Claim or controversy, and Participants agree that any dispute, Claim or controversy may only be initiated or maintained and decided on an individual basis.

Discretionary Authority of the Board of Trustees

The Board of Trustees has the exclusive right and discretion to construe and interpret the Plan and is the sole judge of the standard of proof required in any Claim and the application and interpretation of the Plan. Any dispute as to eligibility, type, amount or duration of benefits or any right or Claim to payments from the Fund will be resolved by the Board or its duly authorized designee under and pursuant to the provisions of the Plan and the Trust Agreement, and its decision is final and binding upon all parties, subject only to judicial review as may be in harmony with Federal labor law. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Facility of Payment

If the Board of Trustees or its designee determines that you cannot submit a Claim or prove that you or your covered Dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan Benefits directly to the Health Care Professional(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan Benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Board of Trustees, the Fund Office nor any other designee of the Plan Administrator will be required to see to the application of the money so paid.

Where to Submit a Claim or File an Appeal

Claim Administrator	Address	Send Appeal to:
Kaiser Foundation Health Plan (including medical, prescription, hearing aid, and vision)	Kaiser Foundation Health Plan, Inc. Claims Department P.O. Box 12923 Oakland, CA 94604-2923	Kaiser Foundation Health Plan, Inc. Special Services Unit P.O. Box 23280 Oakland, CA 94623
Indemnity Medical Plan (including mental health and chemical dependency)	Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007	Carpenters Health and Welfare Trust Fund for California 265 Hegenberger Road, Suite 100 Oakland, CA 94621-1480
Indemnity Plan – Prescription Drug Benefits (For Non-Medicare Retirees and Dependents)	Express Scripts P.O. Box 14711 Lexington, Kentucky 40512	Carpenters Health and Welfare Trust Fund for California 265 Hegenberger Road, Suite 100 Oakland, CA 94621-1480
Indemnity Plan – Prescription Drug Benefits (For Medicare Retirees and Dependents)	Express Scripts P.O. Box 14711 Lexington, Kentucky 40512	Carpenters Health and Welfare Trust Fund for California 265 Hegenberger Road, Suite 100 Oakland, CA 94621-1480
Indemnity Plan – Vision Care Benefits	Vision Service Plan Attn: Out-of-Network Provider Claims P.O. Box 997105 Sacramento, CA 95899-7105	Vision Service Plan Member Appeals 333 Quality Drive Rancho Cordova, CA 95670
Indemnity Plan – Hearing Aid Benefits	Carpenters Health and Welfare Trust Fund for California 265 Hegenberger Road, Suite 100 Oakland, CA 94621-1480	Carpenters Health and Welfare Trust Fund for California 265 Hegenberger Road, Suite 100 Oakland, CA 94621-1480

Indemnity Plan Coordination of Benefits (COB) and Third Party Liability

Coordination of Benefits with Other Plans

If an Eligible Individual is entitled to benefits from another Group Plan for health care expenses for which benefits are also due from this Fund, then the benefits provided by this Plan will be paid in accordance with the following provisions, not to exceed the dollar amount of benefits that would have been paid in the absence of other group coverage or 100% of the Covered Expenses actually incurred by the Eligible Individual.

1. If you are the Retiree, Fund benefits will be provided without reduction, except as provided in rule 7 below, in which case Fund benefits otherwise payable will be determined after the benefits of the other employer-sponsored Group Plan.
2. If you are the Dependent Spouse of a Retiree, Fund benefits will be paid for eligible expenses not covered by the other Group Plan.
3. If a Claim is made for a Dependent child whose parents are not separated or divorced, the benefits of the Group Plan that covers the Eligible Individual as a Dependent child of a parent whose date of birth, excluding year of birth, occurs earlier in the calendar year, will be determined before the benefits of the Group Plan that covers that Eligible Individual as a Dependent child of a parent whose date of birth, excluding year of birth, occurs later in the calendar year.
4. If the other Group Plan does not have the provisions of rule 3 above regarding Dependents the provisions of the other Group Plan will determine the order of benefits.
5. If a Claim is made for a Dependent child whose parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan that covers the child as a Dependent of the parent with custody of the child will be determined before the benefits of a Plan that covers the child as a Dependent of the parent without custody.
6. If a Claim is made for a Dependent child whose parents are separated or divorced and the parent with custody of the child has remarried, the benefits of a Plan that covers the child as a Dependent of the parent with custody will be determined before the benefits of a Plan that covers the child as a Dependent of the stepparent, and the benefits of a Plan that covers that child as a Dependent of the stepparent will be determined before the benefits of a Plan that covers that child as a Dependent of the parent without custody.
7. In the case of an Eligible Individual Dependent child whose parents are separated or divorced and where there is a court decree that establishes financial responsibility for the medical, dental or other health care expenses with respect to the child; then notwithstanding rules 4 and 5 above, the parent with financial responsibility will be determined before the benefits of any other plan that covers the child as a Dependent child.
8. When rules 1 through 7 do not establish an order of benefit determination, Fund benefits will be provided without reduction, if the Eligible Individual has been eligible continuously for benefits from this Fund for a longer period of time than he or she has been continuously eligible for benefits from the other Group Plan, provided that:

   - The Group Plan covering an Eligible Individual as an active employee or Dependent of an active employee provides benefits without reduction and the benefits of a Group Plan covering the Eligible Individual as a laid-off or retired employee will be determined second.

Coordination with Preferred Provider Agreements

In addition to any other limitations applicable to this Plan or its Coordination of Benefits provisions, where this Plan, as "secondary", is coordinating benefits with another plan that has entered into a Preferred Provider Agreement with a medical or hospital provider, this Plan will pay no more than the difference between the lesser of:

- The normal charges billed for the expenses by the provider; or
- this Plan's contractual rate; or
- the contractual rate under the other plan's Preferred Provider Agreement.

Coordination with Medicaid

Benefits payable by this Plan will be made in compliance with any assignment of rights made by or on behalf of an Eligible Individual as required by California's plan for medical assistance approved under Title XIX, Section 1912(a)(1)(A) of the Social Security Act (Medicaid).

If the state has provided medical assistance (under Medicaid) where this Plan has a legal liability to make payment for services, payment will be made by this Plan for Claims submitted within one year from the date expenses were incurred. Reimbursement to the state, like any other entity that has made payment for medical assistance where this Plan has a legal liability to make payment, will be equal to Plan benefits or the amount actually paid, whichever is less.

Coordination with Prepaid Plans (such as HMOs)

Regardless of whether this Plan may be considered primary or secondary under its coordination of benefits provisions, in the event a Participant or Dependent:

- Has coverage under the Indemnity Medical benefits of this Plan; and
- has coverage under a prepaid program under another Group Plan (regardless of whether the Participant or Dependent must pay a portion of the premium for that plan); and
- uses the prepaid program,

then this Plan will only reimburse the Copayments required of the Eligible Participant or Dependents under the prepaid program, and only to the extent Copayments are required.

Third-Party Liability

If an Eligible Individual has an Illness, Injury, disease or other condition for which a third party (or parties) is or may be liable or legally responsible by reason of an act, omission, or insurance coverage of that third party or parties (referred to in this SPD collectively as "responsible third party"), the Fund will not be liable to pay any benefits. However, upon the execution and delivery to the Fund of all documents it requires to secure the Plan's right of reimbursement, including without limitation a Reimbursement Agreement, the Fund may pay benefits on account of hospital, medical or other expense in connection with, or arising out of, that Injury, Illness, disease or other condition. The Fund will have all rights as outlined in the Third-Party Liability section (SECTION 7.02) of the Rules and Regulations printed at the end of this SPD (beginning on page 122 of this document).

The Fund shall be reimbursed first, before any other Claims, for 100% of benefits paid by the Fund from any recovery received by way of judgment, arbitration award, verdict, settlement or other source by the

Eligible Individual or by any other person or party for the Eligible Individual, pursuant to such Illness, Injury, disease or other condition, including recovery from any under-insured or uninsured motorist coverage or other insurance, even if the judgment, verdict, award, settlement or any recovery does not make the Eligible Individual whole or does not specifically include medical expenses. The Fund shall be reimbursed from said recovery without any deduction for legal fees incurred or paid by the Eligible Individual. The Eligible Individual and/or his or her attorney must promise not to waive or impair any of the rights of the Fund without written consent. In addition, the Fund shall be reimbursed for any legal fees incurred or paid by the Fund to secure reimbursement of said benefit paid by the Fund.

If the Fund pays any benefits because of such Illness, Injury, disease or other condition, the Fund shall also have an automatic lien and/or constructive trust on that portion of any recovery obtained by the Eligible Individual or by any other person or party for the Eligible Individual, for such Illness, Injury, disease or other condition which is due for said benefits paid by the Fund, even if the judgment, verdict, award, settlement or any recovery does not make the Eligible Individual whole or does not specifically include medical expenses. Such lien may be filed with the Eligible Individual, his or her agent, insurance company, any other person or party holding said recovery for the Eligible Individual, or the court; and such lien shall be satisfied from any recovery received by the Eligible Individual, however classified, allocated, or held.

If reimbursement is not made as specified, the Fund, at its sole option, may take any legal and/or equitable action to recover the amount that was paid for the Eligible Individual's Illness, Injury, disease or other condition (including any legal expenses incurred or paid by the Fund) and/or may offset future benefits payments by the amount of such reimbursement (including any legal fees incurred or paid by the Fund). The Fund, at its sole option, may cease paying benefits, if there is a reasonable basis to determine that the Eligible Individual will not honor the terms of the Plan, or there is a reasonable basis to determine that this section is not enforceable.

Information Required by the Employee Retirement Income Security Act of 1974 (ERISA)

General Plan Information

The name and type of administration of the Plan:

The name of the Plan is Carpenters Health and Welfare Trust Fund for California. The Plan Sponsor is the Joint Board of Trustees of the Carpenters Health and Welfare Trust Fund for California. The Administrative Office of the Fund is located at the following address:

Carpenter Funds Administrative Office of Northern California, Inc. 265 Hegenberger Road, Suite 100
Oakland, CA 94621-1480
Phone: (510) 633-0333
Email: benefitservices@carpenterfunds.com Website: www.carpenterfunds.com

The Fund Office will provide any Plan Participant or beneficiary, upon written request, information as to whether a particular Employer is contributing to this Fund and, if so, that Employer's address.

Type of Plan:

The Plan is an employee welfare benefit plan, providing medical, prescription drug, hearing aid, and vision care benefits to Participants and their eligible Dependents.

Internal Revenue Service identification number and Plan number:

The Employer Identification Number (EIN) issued to the Board of Trustees is 94-1234856. The Plan number is 501.

Name and address of the person designated as agent for the service of legal process is:

William Feyling, Administrator
c/o Carpenters Health and Welfare Trust Fund for California
265 Hegenberger Road, Suite 100
Oakland, CA 94621-1480
Service of legal process may also be made upon the Board of Trustees or an individual Trustee.

This program is maintained pursuant to various collective bargaining agreements.

Copies of the collective bargaining agreements are available for inspection at the Fund Office during regular business hours, and upon written request, will be furnished by mail. A copy of any collective bargaining agreement that provides for contributions to the Fund will also be available for inspection within 10 calendar days after written request at any of the Local Union offices or at any office of any Contributing Employer to which at least 50 Plan Participants report each day.

Names and business addresses of the members of the Board of Trustees:

Employer Trustees	Labor Trustees
Robert Alten Alten Construction, Inc. 1141 Marina Way South Richmond, CA 94804	Jacob Adiarte Northern California Carpenters Regional Council 265 Hegenberger Road, Suite 200 Oakland, CA 94621
Nancy Brinkerhoff Ironwood Commercial Builders 3953 Industrial Way, Suite E Concord, CA 94520	Jay Bradshaw Northern California Carpenters Regional Council 265 Hegenberger Road, Suite 200 Oakland, CA 94621
Donald A. Dolly Condon-Johnson & Associates, Inc. 5091 Lone Tree Way Antioch, CA 94531	Edward Gable Northern California Carpenters Regional Council 265 Hegenberger Road, Suite 200 Oakland, CA 94621
Randy Jenco Viking Construction Company P.O. Box 1508 Rancho Cordova, CA 95741	Daniel Gregg Carpenters Local Union No. 713 1050 Mattox Road Hayward, CA 94541
Mike Mencarini Unger Construction Company 910 X Street Sacramento, CA 95818	Sean Hebard Northern California Carpenters Regional Council 265 Hegenberger Road, Suite 200 Oakland, CA 94621
Scott Smith James E. Roberts-Obayashi Corporation 20 Oak Court Danville, CA 94526	Dan McCulloch Carpenters Local Union No. 751 1706 Corby Avenue Santa Rosa, CA 95407
Kathryn Cahill Thompson Cahill Contractors LLC 425 California Street, Suite 2200 San Francisco, CA 94104	Daniel Nuncio Carpenters Local Union No. 701 1361 N. Hulbert Avenue Fresno, CA 93728

The Plan's requirements with respect to eligibility for benefits:

Please refer to the **Enrollment and Eligibility** section of this SPD beginning on page 19.

Certain factors could interfere with payment of benefits from the Plan (result in your disqualification or ineligibility, denial of your Claim, or loss, forfeiture, or suspension of benefits you might reasonably expect):

Examples of such factors are listed below:

> Any factors affecting your receipt of benefits will depend on your particular situation. If you have questions, contact the Fund Office at (510) 633-0333.

- **Overlooking the Plan's requirements for Utilization Review (applicable only to Non-Medicare eligible Retirees and Dependents).** Certain Indemnity Medical Plan benefits will not be payable if you fail to follow the Plan's requirements for Utilization Review. See page 48 for information on the Indemnity Medical Plan's Utilization Review requirements. Other benefits (such as prescription drugs and mental health and chemical dependency) also have Utilization Review requirements.

- **Use of a Non-Contract Providers (applicable only to Non-Medicare eligible Retirees and Dependents).** You will not receive the highest level of coverage available for many of the health care services described in this booklet unless you use Contract Providers (also called "participating" or "network" providers). For some services and supplies, you will not receive any benefits if you do not use Contract Providers. See the section on the health care benefits described in the "**Schedule of Non-Medicare Eligible Indemnity Medical Plan Benefits**" beginning on page 54 for more information.

- **Failure to enroll in both Parts A and B of Medicare.** When you become eligible for Medicare, the Indemnity Medical Plan will assume that you are enrolled in both parts of A and B of Medicare, ***regardless of whether or not you have actually enrolled***. The Plan will pay only 20% of Medicare's allowed charges and you will be responsible for the rest. You will not be permitted to enroll in Kaiser unless you have enrolled in both parts A and B of Medicare and assigned your Medicare benefits to Kaiser.

- **Failure to submit Claims in a timely manner.** You should submit all health care Claims within 90 days from the date on which covered services were rendered. In no event will benefits be allowed if you file a Claim more than 1 year from the date on which services were rendered.

- **The Plan's provisions for coordination of benefits.** If you have health care coverage under another plan, payment of benefits will be coordinated with payment of benefits by that other plan. See "**Coordination of Benefits (COB) and Third Party Liability**" on page 111 for more information.

Note: You are required to notify the Fund Office of other coverage. If you don't notify the Fund of other insurance, the Plan may be unable to coordinate your benefits which could result in an overpayment on your Claim.

- The Plan's provisions regarding payment from another source. You will be required to reimburse the Fund for benefits it pays if you or a Dependent is injured by the acts of a third party and you collect payment for that injury from another source. See "Third-Party Liability" on page 113 for more information.

- Failure to update your address. If you move, it is your responsibility to keep the Fund Office informed about where it can reach you. Otherwise, you may not receive important information about your benefits.
- Failure to keep records of your self-payments for Retiree health and welfare benefits. See "Enrollment and Eligibility" on page 19 and "Termination of Eligibility" on page 24 for information on eligibility and termination of eligibility.
- See other sources of information that apply to you, including your Evidence of Coverage from Kaiser (if you are enrolled in Kaiser) or the vision benefits brochure from VSP (if you are enrolled in the Indemnity Medical Plan).

Source of financing of the Plan and identity of any organization through which benefits are provided:

All contributions to the Fund are made by Contributing Employers in compliance with collective bargaining agreements in force with the Carpenters 46 Northern California Counties Conference Board or one of its affiliated Local Unions; or by the Regional Council or one of its affiliated Local Unions with respect to certain of their Employees pursuant to Board regulations; or a recognized Subscriber Agreement.

Contributions are calculated pursuant to the applicable Collective Bargaining Agreement or Subscriber Agreement.

Benefits are provided through the Carpenters Health and Welfare Trust Fund for California and the organizations shown in the chart at the end of this section.

The date of the end of the Plan Year:

The date of the end of the Plan Year is August 31.

Claims and Appeals Procedures

Claims and appeals procedures are described in the section of this booklet starting on page 93 and in the Kaiser and VSP Evidence of Coverage or Certificate of Coverage.

Future of the Plan and Trust; Plan Amendment and Termination Rights:

The benefits provided by this Plan, while intended to remain in effect indefinitely, can be guaranteed only so long as the parties to collective bargaining agreements continue to require contributions into the Fund sufficient to underwrite the cost of the benefits. Should contributions cease and the reserves be expended, the Trustees would no longer be obligated to furnish coverage. These are not guaranteed lifetime benefits.

The Board of Trustees has the right to change or discontinue the types and amounts of benefits covered under this Plan; and the eligibility rules, including those rules providing extended or accumulated eligibility even if the extended eligibility has already been accumulated.

The Plan may be terminated based on the authority designated under the Trust Agreement. In the event of termination of the Trust, any and all monies and assets remaining in the Trust, after payment of expenses, will be used for the continuance of the benefits provided by the then existing program of benefits, until these monies and assets have been exhausted. The Board of Trustees has the right to revise, reduce, or otherwise adjust benefits in any reasonable manner in connection with termination of the Plan.

Organizations Through Which Benefits Are Provided:

Name and Address of Organization	
Anthem Blue Cross of California 21555 Oxnard Street Woodland Hills, CA 91367 Administers Contract Provider program and required Utilization Reviews for Indemnity Medical Plan; does not guarantee payment of medical benefits. (Benefits are self-funded by the Trust Fund.)	**Kaiser Foundation Health Plan** Northern California Region 1950 Franklin Street Oakland, CA 94612 Provides prepaid medical, drug, vision and hearing aid benefits to Participants enrolled in Kaiser, with guaranteed payment of these benefits.
Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670 Administers vision Plan for Participants in the Indemnity Medical Plan; does not guarantee payment of vision benefits. (Benefits are self-funded by the Trust Fund.)	**Express Scripts** P.O. Box 2015 Pine Brook, NJ 07058 Administers prescription drug benefits for Indemnity Medical Plan Participants; does not guarantee payment of prescription drug benefits. (Benefits are self-funded by the Trust Fund.)

Your ERISA Rights

As a Participant in the Carpenters Health and Welfare Trust Fund for California, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and subsequent amendments. ERISA provides that all Plan participants are entitled to the following rights:

Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan. These documents include insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These include insurance contracts, collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may impose a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to provide each Participant with a copy of this Summary Annual Report.

Continue Group Health Plan Coverage

You have the right to continue health care coverage for yourself, Spouse, or Dependent children if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

You may also have other health coverage alternatives to COBRA available to you that can be purchased through the **Health Insurance Marketplace.** The Marketplace helps people without health coverage find

and enroll in a health plan, (California residents see: www.coveredca.com. Non-California residents see your state Health Insurance Marketplace or www.healthcare.gov).

In the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace- purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a Spouse's plan), if you request enrollment in that other plan within 30 days of losing coverage under this Plan, even if that other plan generally does not accept late enrollees.

Prudent Actions by Plan Fiduciaries

In addition to defining rights for Plan Participants, ERISA imposes duties upon the people and entities responsible for the operation of employee benefit plans. The people and entities 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, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Right

If your Claim for a welfare benefit is denied or ignored, in whole or in part, you have a right: To know why the Claim was denied or ignored; to obtain copies of documents relating to the decision without charge; and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive it 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 Plan 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 once you have exhausted the appeals process described in "Claims and Appeals Procedures" in this booklet. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you 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 or entity 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.

Assistance With Your Questions

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 if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory. Alternatively, you may obtain assistance by calling EBSA toll-free at (866) 444-EBSA (3272) or writing to the following address:

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

You may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of EBSA toll free at (866) 444-EBSA (3272) or contacting the EBSA field office nearest you.

You may also find answers to your Plan questions and a list of EBSA field offices at www.dol.gov/ebsa.

Rebates

In the event that the Health and Welfare Plan receives a "Medical Loss Ratio" (MLR) Rebate, the monies received will be used for the exclusive purpose of providing benefits to Participants in the Plan and their beneficiaries and defraying reasonable expenses of administering the Plan.

Headings, Font and Style Do Not Modify Plan Provisions

The headings of chapters and subchapters and text appearing in **bold** or CAPITAL LETTERS and font and size of sections, paragraphs and subparagraphs are included for the sole purpose of generally identifying the subject matter of the substantive text for the convenience of the reader. The headings are **not** part of the substantive text of any provision, and they **should not be construed to modify the text of any substantive provision in any way**.

Privacy of Health Information

The Plan is required to protect the confidentiality of your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services. The Plan's Notice of Privacy Practices, distributed to all Plan Participants and Dependents when they first become eligible, explains what information is considered "Protected Health Information (PHI)." It also tells you when the Plan may use or disclose this information, when your permission or written authorization is required, how you can get access to your information, and what actions you can take regarding your information. (See Section 8.10. of the Rules and Regulations printed at the end of this SPD for more information, including a definition of Protected Health Information.)

Your rights under HIPAA include the right to:

- Receive confidential communications of your Protected Health Information, as applicable;
- see and copy your health information;
- receive an accounting of certain disclosures of your health information;
- amend your Protected Health Information under certain circumstances; and
- file a complaint with the Plan's Privacy Official or with the Secretary of Health and Human Services if you believe your rights under HIPAA have been violated.

If you need another copy of the Plan's Notice of Privacy Practices, notices are available online at www.carpenterfunds.com or contact the Fund Office.

In compliance with HIPAA Security regulations, the Plan has implemented administrative, physical and technical safeguards that protect the confidentiality and integrity of electronic PHI that it creates, receives, maintains or transmits.

CARPENTERS HEALTH AND WELFARE TRUST FUND FOR CALIFORNIA

RULES AND REGULATIONS FOR RETIREES

Amended and Restated Effective March 1, 2024 Through Amendment 62

ARTICLE 1. DEFINITIONS

Unless the context or subject matter otherwise requires, the following definitions will govern in these Rules and Regulations:

SECTION 1.01. The term **"Active Employees' Plan"** means the rules and regulations governing the plan for Active participants.

SECTION 1.02. For Emergency Services, non-Emergency Services provided by Non-Contract Providers at Contract facilities, and Air Ambulance services, the Allowed Charge is the Recognized Amount. For all other services, the term **"Allowed Charge"** means the lesser of:

a. The dollar amount this Fund has determined it will allow for covered Medically Necessary services or supplies performed by Non-Contract Providers. The Fund's Allowed Charge amount is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), usual, customary and reasonable (UCR), prevailing or any similar term. A charge billed by a provider may exceed the Fund's Allowed Charge. The Fund reserves the right to have the billed amount of a claim reviewed by an independent medical review firm to assist in determining the amount the Fund will allow for submitted claims. When using Non-Contract Providers, the Eligible Individual is responsible for any difference between the actual billed charge and the Fund's maximum Allowed Charge, in addition to any copayment and percentage coinsurance required by the Plan.

b. The Provider's actual billed charge.

c. The Fund has adopted a Medicare based reimbursement strategy for Non-Contract Hospital, Non-Contract Facility and other Non-Contract Providers where the maximum amount payable by this Plan is a percentage of the amount that would have been payable in accordance with Medicare allowable payments. The Plan limits Medically Necessary *out-patient* services from Non-Contract Providers who are not registered with the Centers for Medicare & Medicaid Services (CMS) to a maximum allowable charge of $200 per appointment, subject to the Non-Contract deductible and coinsurance. Benefits paid *for in-patient* services from a Non-Contract Provider are based on a percentage of that provider's CMS registered fee; there will be no benefits available for in-patient services from a Non-Contract Provider who is not registered with CMS.

SECTION 1.03. The term **"Ancillary Services"** means, with respect to a Contract Health Care Facility:

a. Items and services related to emergency medicine, anesthesiology, pathology, radiology and neonatology, whether provided by a physician or non-physician practitioner,

b. Items and services provided by assistant surgeons, hospitalists, and intensivists;

c. Diagnostic services, including radiology and laboratory services; and

d. Items and services provided by a Non-Contract Provider if there is no Contract Provider who can furnish such item or service at such facility.

SECTION 1.04. The term **"Board"** means the Board of Trustees established by the Trust Agreement.

SECTION 1.05. The term **"Building and Construction Industry"** means all building construction and all heavy, highway and engineering construction, including but not limited to construction, erection, alteration, repair, modification, demolition, addition or improvement in whole or in part of any building, structure, street (including sidewalk curb and gutter), highway, bridge, viaduct, railroad, tunnel, airport, water supply, irrigation, flood control and drainage system, sewer and sanitation project, dam, power house, refinery, aqueduct, canal, river and harbor project, wharf, deck, breakwater, jetty, quarrying of breakwater or riprap stone, or any other operation incidental to such construction work. This includes

renovation work, maintenance work, mill-cabinet or furniture manufacturing or repair work or installation of any modular systems or any other premanufactured materials performed for any public or private employer.

SECTION 1.06. The term **"Chiropractor"** means a licensed practitioner who specializes in the non-surgical treatment and restoration of normal function of the musculoskeletal and nervous system, by manipulation and treatment of the structures of the human body, especially those of the spinal column.

SECTION 1.07. The term **"Coinsurance"** means that portion of eligible expenses for which the covered person has financial responsibility to pay. Coinsurance amounts are addressed in Article 3.

SECTION 1.08. The term **"Coinsurance Maximum"** means the maximum amount of Coinsurance each covered person or family is responsible for paying during a Calendar Year before the Coinsurance required by the Plan ceases to apply (for most but not all services). When the Coinsurance Maximum is reached, the Plan will pay 100% of additional coinsurance related to most covered expenses for the remainder of the Calendar Year. There is no Coinsurance Maximum for Non-Contract provider expenses.

SECTION 1.09. The term **"Concurrent Review"** means the process whereby the Professional Review Organization (PRO) under contract to the Fund determines the number of authorized days considered medically necessary that are eligible for unreduced benefit coverage according to the terms of the Plan once an Eligible Individual has been confined to a Hospital.

SECTION 1.10. The term **"Continuing Care Patient"** means an individual who, with respect to a provider or facility:

a. is undergoing a course of treatment for a serious and complex condition from the provider or facility;

b. is undergoing a course of institutional or inpatient care from the provider or facility;

c. is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;

d. is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

e. is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

SECTION 1.11. The term **"Contract Hospital"** means a Hospital that has a contract in effect with the Fund's Preferred Provider Organization (PPO).

SECTION 1.12. The term **"Contract Facility"** means a health care or substance abuse treatment facility that has a contract in effect with the Fund's Preferred Provider Organization (PPO).

SECTION 1.13. The term **"Contract Physician" or "Contract Provider"** means a Physician or other health care provider that has a contract in effect with the Fund's Preferred Provider Organization (PPO).

SECTION 1.14. The term **"Contributing Employer"** means an employer who is required by a collective bargaining agreement, with the Union or Subscriber's Agreement to make contributions to the Fund or who in fact makes one or more contributions to the Fund.

The term "Contributing Employer" also includes any Local Union or Regional Council, any labor council or other labor organizations with which a Local Union or Regional Council is affiliated, and any corporation, trust or other entity which provides services to the Fund or in the enforcement or administration of contracts requiring contributions to the Fund, or in the training of apprentice or journeyman carpenters, which makes contributions to the Fund with respect to the work of its Employees pursuant to a

Subscriber's Agreement and approved by the Board of Trustees, provided the inclusion of any Local Union, Regional Council, labor council, other labor organization, corporation, trust or other entity as a Contributing Employer is not a violation of any existing law or regulation. Any Local Union, Regional Council, labor council, other labor organization, corporation, trust or other entity is a Contributing Employer solely for the purpose of making contributions with respect to the work of its respective Employees and has no other rights or privileges under the Trust Agreement as a Contributing Employer.

SECTION 1.15. The term **"COVID-19 National Emergency**" means the emergency period declared by the United States President on March 13, 2020, and renewed on February 18, 2022, to address the Coronavirus Disease 2019 Pandemic.

SECTION 1.16. The term **"Copayment"** means the amount the Eligible Individual is required to pay for a service or Drug before Plan benefits are payable.

SECTION 1.17. The term **"Covered Expense(s)"** means only those charges which are Allowed Charges under the Plan and which are made for the Medically Necessary care and treatment of a non-occupational Illness or Injury, except that certain routine preventive services are Covered Expenses when specifically provided in the Plan. Covered Expenses include only those charges incurred by an Eligible Individual while eligible for benefits under this Plan. In no event will a Covered Expense exceed either the Allowed Charge for a service provided by a Non-Contract Provider, or for a Contract Provider the contractual rate for the service under a preferred provider agreement.

SECTION 1.18. The term **"Cost sharing"** means the amount a Participant or Dependent is responsible for paying for a covered item or service under the terms of the plan. Cost sharing generally includes copayments, coinsurance and amounts paid towards deductibles, but does not include amounts paid towards premiums, balance billing by Non-Contract Providers, or the cost of items or services that are not covered under the plan. The Cost Sharing Amount for Emergency and Non-emergency Services at Contract Facilities performed by Non-Contract Providers, and air ambulance services from Non-Contract Providers will be based on the Recognized Amount.

SECTION 1.19. The term **"Deductible"** means the amount of Eligible Medical Expenses you are responsible for paying before the Plan begins to pay benefits. An individual Deductible applies to an individual person, while the family Deductible applies to all members of the family that are covered under the Plan. Everything paid toward an individual Deductible counts toward the family Deductible. The amount of Deductibles is discussed in SECTION 3.01.

SECTION 1.20. The term **"Dentist"** means a dentist licensed to practice dentistry in the state in which he or she provides treatment.

SECTION 1.21. The term **"Dependent"** means:

a. The Retiree's lawful Spouse or qualified Domestic Partner.

b. A child who is:

   (1) the Retiree's natural child, stepchild or legally adopted child or a child of the Retiree required to be covered under a Qualified Medical Child Support Order, who is younger than 26 years of age, whether married or unmarried. Adopted children are eligible under the Plan when they are placed for adoption;

   (2) an unmarried child for whom the Retiree has been appointed legal guardian, provided the child is younger than 19 years of age and is considered the Retiree's dependent for federal income tax purposes;

   (3) an unmarried child of the Retiree's qualified Domestic Partner, provided the child is younger than 19 years of age and is primarily dependent on the Retiree for financial support;

(4) an unmarried child eligible under paragraph (2) or (3) above other than age who is 19 but less than 23 years of age and a full time student at an accredited educational institution, provided the child otherwise meets the requirements of paragraph (2) or (3) above; or

(5) an unmarried child of the Retiree (or the Retiree's spouse or qualified Domestic Partner) of any age who is prevented from earning a living because of mental or physical disability, provided the child was disabled and eligible as a Dependent under this Plan before reaching the Limiting Age described in paragraphs (1), (2), (3) or (4) above, and provided the child is primarily dependent on the Retiree for financial support.

c. In accordance with ERISA Section 609(a), this Plan will provide coverage for a child of a Retiree if required by a Qualified Medical Child Support Order, including a National Medical Support Order. A Qualified Medical Child Support Order or National Medical Support Order will supersede any requirements in the Plan's definition of Dependent stated above.

SECTION 1.22. The term **"Domestic Partner"** means:

a. A person who the Participant has registered with as a Domestic Partner by any state or local government agency authorized to perform such registrations.

b. Any prior domestic partnership of the Participant has been terminated not less than 6 months prior to the date of enrollment of the subsequent Domestic Partner.

c. Application for domestic partnership with the Participant is properly made as required by the Board of Trustees and all required taxes on the imputed income attributable to Domestic Partner benefits are paid to the Fund when due.

SECTION 1.23. The term **"Drugs"** means any article which may be lawfully dispensed, as provided under the Federal Food, Drug and Cosmetic Act, including any amendments, only upon a written or oral prescription of a Physician or Dentist licensed by law to administer it.

SECTION 1.24. The term **"Eligible for Medicare"** means that the Eligible Individual is eligible for Part A of Medicare without payment of monthly premiums to the Social Security Administration and is eligible for Part B of Medicare whether or not the Eligible Individual has qualified for Part B Medicare benefits by enrollment or other procedure available to him or her.

SECTION 1.25. The term **"Eligible Individual"** means each Retiree and each of his or her eligible Dependents, if any.

SECTION 1.26. The term **"Emergency Medical Condition"** means a medical condition, including a mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or, with respect to a pregnant women, her unborn child in serious jeopardy.

SECTION 1.27. The term **"Emergency Services"** means the following:

1. An appropriate medical screening examination (as required under Section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

2. Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and

treatment as are required under Section 1867 of the Social Security Act to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

Emergency Services furnished by a Non-Contract Provider or Non-Contract emergency facility (regardless of the department of the hospital in which such items or services are furnished) also include post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:

i. The provider or facility determines that the Participant or Dependent is able to travel using nonmedical transportation or nonemergency medical transportation; or

ii. The Participant or Dependent is supplied with a written notice, as required by federal law, that the provider is a Non-Contract Provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any Contract Providers at the facility who are able to treat you, and that you may elect to be referred to one of the Contract Providers listed; and

iii. The Participant or Dependent gives informed consent to continued treatment by the Non-Contract Provider, acknowledging that the Participant or Dependent understands that continued treatment by the Non-Contract Provider may result in greater cost to the Participant or Dependent.

SECTION 1.28. The term **"Enrollment"** means the process of completing and submitting an enrollment form indicating that coverage by the Plan is requested by the Participant. To enroll in the Plan, a person must apply in writing on a form prescribed by the Board and submit documentation as required by the Board. See SECTION 2.03.

SECTION 1.29. The terms **"Experimental"** or **"Investigational"** mean a drug or device, medical treatment or procedure, if:

a. The drug or device cannot be lawfully marketed without approval from the United States Food and Drug Administration and if approval for marketing has not been given at the time the drug or device is furnished; or

b. The drug, device, medical treatment or procedure, or the Patient informed consent document utilized with the drug, device, treatment, or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body servicing a similar function, or if federal law requires such review or approval; or

c. "Reliable Evidence" shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials, is the research, experimental, study or investigational arm of ongoing phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

d. "Reliable Evidence" shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

For purposes of this definition, "Reliable Evidence" means only published reports and articles in peer reviewed authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of 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.

SECTION 1.30. The term **"Extended Care Facility"** or **"Skilled Nursing Facility"** means an institution as defined in Section 1861(j) of the Social Security Act.

SECTION 1.31. The term **"Fund"** means the Carpenters Health and Welfare Trust Fund for California.

SECTION 1.32. The term **"Group Plan"** means any plan providing benefits of the type provided by this Plan which is supported wholly or in part by employer payments.

SECTION 1.33. The term **"Health Care Facility"** (for non-emergency services) means each of the following:

a. A hospital (as defined in Section 1861(e) of the Social Security Act);

b. A hospital outpatient department;

c. A critical access hospital (as defined in Section 1861(mm)(1) of the Social Security Act); and

d. An ambulatory surgical center described in Section 1833(i)(1)(A) of the Social Security Act.

SECTION 1.34. The term **"Home Health Agency"** means a home health care provider which is licensed according to state or local laws to provide skilled nursing and other services on a visiting basis in the Eligible Individual's home and is recognized as a provider under Medicare.

SECTION 1.35. The term **"Hospice"** means a health care facility or service providing medical care and support services, such as counseling to terminally ill persons and their families.

SECTION 1.36. The term **"Hospital"** means any acute care Hospital which is licensed under any applicable state statute and must provide: (1) 24-hour inpatient care, and (2) the following basic services on the premises: medical, surgical, anesthesia, laboratory, radiology, pharmacy and dietary services. A Hospital may include facilities for mental, nervous and/or substance abuse treatment that are licensed and operated according to state law. The requirement that a Hospital must provide surgical, anesthesia and/or radiology services does not apply to facilities for mental, nervous and/or substance abuse treatment.

SECTION 1.37. The term **"Illness(es)"** means a bodily disorder, infection or disease and all related symptoms and recurrent conditions resulting from the same causes.

SECTION 1.38. The term **"Independent Freestanding Emergency Department"** means a health-care facility (not limited to those described in the definition of Health Care Facility) that is geographically separate and distinct from a hospital under applicable State law and provides Emergency Services.

SECTION 1.39. The term **"Injury"** means physical harm sustained as the direct result of an accident, effected solely through external means, and all related symptoms and recurrent conditions resulting from the same accident.

SECTION 1.40. The term **"Licensed Pharmacist"** means a person who is licensed to practice pharmacy by the governmental authority having jurisdiction over the licensing and practice of pharmacy.

SECTION 1.41. The term **"Limiting Age"** means the age at which a child loses eligibility status as defined in SECTION 1.21.

SECTION 1.42. The term **"Medicare"** means the benefits provided under Title XVIII of the Social Security Amendments of 1965.

SECTION 1.43. The term **"Medically Necessary"** with respect to services and supplies received for treatment of an Illness or Injury means those services or supplies determined to be:

a. Appropriate and necessary for the symptoms, diagnosis or treatment of the Illness or Injury;

b. Provided for the diagnosis or direct care and treatment of the Illness or Injury;

c. Within standards of good medical practice within the organized medical community;

d. Not primarily for the personal comfort or convenience of the Patient, the Patient's family, any person who cares for the Patient, any Physician or other health care practitioner or any Hospital or specialized health care facility. The fact that a Physician may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered Medically Necessary for the medical coverage provided by the Plan; and

e. The most appropriate supply or level of service which can safely be provided. For Hospital confinement, this means that acute care as a bed Patient is needed due to the kind of services the Patient is receiving or the severity of the Patient's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

SECTION 1.44. The term **"No Surprises Act"** means the federal No Surprises Act (Public Law 116-260, Division BB).

SECTION 1.45. The term **"Non-Contract Emergency Facility"** means an emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to Emergency Services as defined), that does not have a contractual relationship directly or indirectly with a group health plan or group health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage respectively.

SECTION 1.46. The term **"Non-Contract Hospital"** means a Hospital which does not have a contract in effect with the Fund's Preferred Provider Organization (PPO).

SECTION 1.47. The term **"Non-Contract Facility"** means a health care or substance abuse treatment facility that does not have a contract in effect with the Fund's Preferred Provider Organization (PPO).

SECTION 1.48. The term **"Non-Contract Provider"** means a health care provider who does not have a contractual relationship directly or indirectly with the Plan with respect to the furnishing of an item or service under the Plan.

SECTION 1.49. The term **"Out-of-Network Rate"** with respect to items and services furnished by a Non-Contract Provider, Non-Network emergency facility or Non-Contract Provider of ambulance services, means one of the following:

a. the amount the parties negotiate;

b. the amount approved under the independent dispute resolution (IDR) process;

c. if the state has an All-Payer Model Agreement, the amount that the state approves under that system; or

d. if applicable, if a state law is in effect and applies, the amount determined in accordance with such law.

e. the Allowed Charge described in SECTION 1.02.

SECTION 1.50. The term **"Participant"** means any person who meets the eligibility requirements of the Fund, other than as a Dependent.

SECTION 1.51. The term **"Patient"** means the Eligible Individual who is receiving medical treatment, services or supplies covered by the Plan.

SECTION 1.52. The term **"Physician"** means a physician or surgeon (M.D.), an Osteopath (D.O.), or a Dentist (D.D.S. or D.M.D.) licensed to practice medicine in the state in which he or she practices.

SECTION 1.53. The term **"Plan"** means the Rules and Regulations of the Carpenters Health and Welfare Trust Fund for California for Retirees, including any amendments.

SECTION 1.54. The term **"Plan Year"** means September 1 of any year to August 31 of the succeeding year.

SECTION 1.55. The term **"Podiatrist"** means a health care provider who specializes in the disease, injury and surgery to the feet and who is licensed as a Doctor of Podiatric Medicine (DPM) in the state in which services are performed.

SECTION 1.56. The terms **"Pre-admission Review"** and **"Pre-Admission Certification"** mean the process whereby the Professional Review Organization (PRO) determines the Medical Necessity of an Eligible Individual's elective confinement to a Hospital, and if Medically Necessary, the number of pre-authorized Hospital days eligible for benefit coverage according to the terms of the Plan. Pre-Admission Certification by the PRO includes out-patient procedures listed in SECTION 3.04.b. to determine the Medical Necessity of a surgical procedure eligible for benefit coverage according to the terms of the Plan.

SECTION 1.57. The term **"Preferred Provider Organization"** (PPO) means the entity under contract with the Fund that is responsible for negotiating contracts with Hospitals, Physicians, facilities and other health care providers who agree to provide hospitalization and medical services to Eligible Individuals on the basis of negotiated rates. A list of Contract Providers is available to the Participant or Dependent without charge by visiting the website or by calling the phone number on the ID card. If the Participant or Dependent obtains and relies upon incorrect information about whether a provider is a Contract Provider from the Plan or its administrators, the Plan will apply Contracted Cost-sharing to your claim, even if the provider was Non-Contracted.

SECTION 1.58. The term **"Prepaid Medical Plan"** means a Health Maintenance Organization (HMO) with which the Fund has entered into an agreement to provide health benefits to Eligible Individuals who elect to be covered under that Prepaid Medical Plan.

SECTION 1.59. The term **"Professional Review Organization (PRO)"** or "Review Organization" means an organization under contract with the Fund, which is responsible for determining whether the confinement of an Eligible Individual to a Hospital is Medically Necessary or whether the out-patient procedure listed in SECTION 3.04.b. is Medically Necessary.

SECTION 1.60. The term **"Qualifying Payment Amount (QPA)"** means the amount calculated using the methodology described in 45 CFR § 149.140(a)(16).

SECTION 1.61. The term **"Recognized Amount**" means (in order of priority) one of the following:

a. An amount determined by an applicable All-Payer Model Agreement under Section 1115A of the Social Security Act;

b. An amount determined by a specified state law; or

c. The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

For air ambulance services furnished by Non-Contract Providers, **Recognized Amount** is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

SECTION 1.62. The term **"Retiree"** or **"Retired Employee"** means each person who meets the eligibility rules in SECTION 2.01.a.

SECTION 1.63. The term **"Serious and Complex Condition"** means with respect to a Participant or Dependent under the Plan one of the following:

a. in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent disability;

b. in the case of a chronic illness or condition, a condition that:

   (1) is life-threatening, degenerative, potentially disabling or congenital; and
   (2) requires specialized medical care over a prolonged period of time.

SECTION 1.64. The term **"Spouse"**, wherever it appears in this Plan, will be construed to mean the legal spouse or qualified Domestic Partner of the Retiree.

SECTION 1.65. In the context of Continuity of Care, the term **"Termination"** includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

SECTION 1.66. The term **"Trust Agreement"** means the Trust Agreement establishing the Carpenters Health and Welfare Trust Fund for California, dated March 4, 1953, including any amendment, extension or renewal.

SECTION 1.67. The term **"Union"** means the Carpenters 46 Northern California Counties Conference Board or one of its affiliated unions.

SECTION 1.68. The term **"Utilization Review (UR) Program"** means a program whereby an Eligible Individual who is scheduled for confinement in a Hospital on an elective, non-emergency basis must obtain Preadmission Review and Concurrent Review from the Professional Review Organization (PRO) under contract to the Fund as to the Medical Necessity of that confinement in order to receive unreduced benefit coverage for Covered Expenses incurred as a result of that Hospital confinement. For emergency confinements, the review must be obtained retrospectively.

ARTICLE 2. ELIGIBILITY FOR BENEFITS

SECTION 2.01. Eligibility Rules.

a. **Establishment and Maintenance of Eligibility.** A person will be eligible as a Retiree if he or she meets each of the following requirements specified in Subsections (1) through (6) below:

(1) Ten full Eligibility Credits, based on Hours of Work or Hours of Qualified Military Service credited under SECTION 1.21. or SECTION 6.04.b.(1) of the Rules and Regulations of the Pension Plan, effective June 1, 2012, for the Carpenters Pension Trust Fund for Northern California – Effective for Retirements on or After January 1, 2015:

(a) Ten full Eligibility Credits, based on Hours of Work or Qualified Military Service. He or she is receiving a pension from a related plan which is based on 10 or more years of eligibility credit, based on Hours of Work or Qualified Military Service. In order to satisfy this 10 years of eligibility credit provision, qualifying hours may be used from any of the following related plans:

(i) Carpenters Pension Trust Fund for Northern California

(ii) Carpenter Funds Administrative Office Staff Plan

(iii) Any Lathers Plan merged into the Carpenters Pension Trust Fund for Northern California

(iv) OPEIU Local 3 or 29 (if service was with a Contributing Employer)

(v) Industrial Carpenters Pension Plan

(vi) Any Pension Plan when required by a Collective Bargaining Agreement and/or Memorandum of Understanding negotiated by the Carpenters 46 Northern California Counties Conference Board, and/or any of its affiliates; or

(b) Reciprocity with the Southwest California Carpenters Health and Welfare Trust. A Retiree who is receiving a Service Pension from the Carpenters Pension Trust Fund for Northern California that is based on reciprocal eligibility credits from the Southwest Carpenters Pension Trust may use hours worked under the Southwest Carpenters Health and Welfare Trust to satisfy this Fund's recent attachment eligibility requirements described in Subsections 2.01.a.(2), (3) and (4).

A Retiree who would satisfy this Fund's eligibility requirements outlined in SECTION 2.01.a.(1)(a) absent the Southwest Carpenters eligibility credits may choose this Fund's retiree health and welfare coverage. If the Retiree elects coverage under this Fund, the required self-payment amount will be based on the years of service under this Fund only, and not on the combined years of service under the two trust funds.

(2) He/She has worked at least 300 hours in covered employment for a Contributing Employer, during which time contributions have been required to be paid into the Active Employees' Plan A, Plan B or Plan R, in each of the 2 calendar years immediately preceding the calendar year in which his/her pension effective date occurs (This requirement will be waived for a Retiree who first qualifies for a service pension during the COVID-19 National Emergency (effective March 13, 2020). For purposes of this provision, the 300 hour requirement can be satisfied by:

(a) hours of disability credit granted under the provisions of the Active Employees' Plan;

(b) hours of disability credit granted under the provisions of the Carpenters Pension Trust

Fund for Northern California; or

(c) hours worked in the year of retirement even if not a full calendar year.

<u>Paragraphs (3) and (4) below are effective for retirements on or after January 1, 2007</u>.

(3) In 3 of the last 5 calendar years immediately preceding the calendar year in which his pension effective date occurred, he has worked at least 400 hours per year in covered employment for a Contributing Employer, during which time contributions were required to be paid into the Active Employees' Plan A, Plan B or Plan R. For purposes of this provision, the 400-hour requirement can be satisfied by counting hours worked in the year of retirement even if not a full calendar year. Hours of disability credit may not be used to satisfy this requirement.

(4) He did not engage in any hours of work for wages or profit in the Building and Construction Industry for an entity that is not a Contributing Employer or not a contributing employer to a related plan that is signatory to the International Reciprocal Agreement for Carpenters Health and Welfare Funds, including self-employment, during the calendar year in which his pension effective date occurred, and in each of the 2 immediately preceding calendar years.

(5) For a Retiree who was awarded a Service Pension from the Carpenters Pension Trust Fund for Northern California with a pension effective date from September 1, 2010, through August 31, 2013, and whose last work was in covered employment for a Contributing Employer, the "hours in covered employment" requirements of SECTION 2.01.a.(2) and (3) may be satisfied by proof that he or she was on the "out of work" list at a local union affiliated with the Carpenters 46 Northern California Conference Board.

(6) He makes the required self-payments in a form and manner determined from time to time by the Board.

b. **When Participation Begins.** Except as provided in SECTION 2.01.c., a person who is eligible as a Retiree will begin participation in this Plan on the earliest of the following dates:

(1) The first day of the month following exhaustion of eligibility provided by his/her Hour Bank under the Active Employees' Plan;

(2) If applicable, the first day of the month following exhaustion of eligibility as an Active Employee as provided through the health care continuation coverage provisions of the Employee Retirement Income Security Act, Sections 601 et seq., as amended (COBRA); or

(3) A Retiree's Dependent becomes eligible on the date the Retiree is eligible; or, in the case of a new Dependent Spouse, biological child, legally adopted child or legal guardianship child, on the date the Retiree acquires the new Dependent, if that is later, provided the Retiree enrolls the new Spouse within 60 days of the marriage and the new Dependent child within 60 days of the child's birth or adoption or date the Retiree became the child's legal guardian. These provisions are subject to the Fund's receipt of an enrollment form with all required information. Under the Fund's Prepaid Medical Plan, eligibility for Dependents may be deferred subject to receipt of a completed enrollment form by the Prepaid Medical Plan. A Dependent's eligibility may be deferred or subject to termination if the Participant fails to provide to the Fund all of the information regarding the Dependent that is required to be provided by federal law.

(4) A Retiree's Domestic Partner (including, if applicable, the children of a Domestic Partner) becomes eligible on the date the Retiree is eligible; or, in the case of a new Domestic Partner (including if applicable, the children of a Domestic Partner), on the first of the second month following the month of Enrollment, date the Retiree enrolled if that is later, provided the Retiree enrolls the new Domestic Partner within 60 days of the date of registration as

described in SECTION 1.22. This provision is subject to the Fund's receipt of an enrollment form with all required information. Under the Fund's Prepaid Medical Plan, eligibility for a Domestic Partner and if applicable, the children of a Domestic Partner, may be deferred subject to receipt of a completed enrollment form by the Prepaid Medical Plan. A Domestic Partner, including the children of a Domestic Partner may be deferred or subject to termination if the Participant fails to provide the Fund all of the information regarding the Domestic Partner and children of the Domestic Partner that is required to be provided by federal law.

c. **Late Enrollment Provisions.** Notwithstanding the provisions of SECTION 2.01.b., a Retiree may defer enrollment in the Plan for the Retiree and/or his/her eligible Dependents under any of the following circumstances:

(1) The Retiree may Late Enroll in the Plan upon one of these events:

(a) Medicare. A Retiree or Dependent not Eligible for Medicare may defer enrollment in the Plan until the Retiree or Dependent becomes Eligible for Medicare. However, in order for a Dependent to be enrolled in the Plan, the Retiree must also be enrolled, except in the case of a surviving Spouse. The Retiree or Dependent must file an application with the Fund Office to enroll in the Plan within 90 days of becoming entitled to Medicare coverage, except that a Spouse who became entitled to Medicare before the Retiree may enroll when the Retiree enrolls regardless of the Spouse's Medicare entitlement date.

(b) Acquisition of New Dependent. If a Retiree who did not enroll in the Plan when first eligible in accordance with SECTION 2.01.b. subsequently acquires a new Spouse or Dependent child(ren) by birth, adoption, placement for adoption or legal guardianship, the Retiree may enroll him/herself and his/her newly acquired Spouse and Dependent child(ren) in the Plan no later than 31 days after the date the new Dependent is acquired. However, in order for the Retiree to enroll in the Plan, the newly acquired Dependent(s) must also be enrolled.

(c) Medicaid or Children's Health Insurance Program. A Retiree who did not enroll in the Plan for Retiree or Dependent coverage on the date the Retiree or Dependent first became eligible will have the opportunity to request enrollment in the Plan within 60 days of either of the following events:

i. the date the Retiree and/or Dependent loses eligibility for Medicaid, a state Children's Health Insurance Program (CHIP), or other public program other than Medicare; or

ii. the date the Retiree and/or Dependent becomes eligible to participate in a premium assistance program under Medicaid or the Children's Health Insurance Program (CHIP).

(2) If a Retiree did not enroll in the Plan for Retiree or Dependent coverage on the date the Retiree or Dependent first became eligible because the Retiree or Dependent had other health coverage:

(a) If the other coverage was under another health insurance policy or program (including COBRA Continuation Coverage or individual insurance), or health coverage through the

Affordable Care Act Health Insurance Marketplace or state exchange, and the Retiree or Dependent ceases to be covered by that other health coverage, the Retiree and eligible Dependent may enroll in this Plan within 31 days after termination of the other coverage,

(b) if that other coverage terminated due to any of the reasons specified in Subsections (i), (ii), (iii), or (iv) below.

(i) The loss of eligibility for the other coverage as a result of termination of employment, reduction in the number of hours of employment, or death, divorce or legal separation;

(ii) The termination of employer contributions toward the other coverage; or

(iii) If the other coverage was COBRA coverage, the exhaustion of that coverage. COBRA coverage is exhausted if it ceases for any reason other than the failure of the individual to pay the applicable COBRA premium on a timely basis.

(iv) In the case of coverage offered through an HMO, or other arrangement, in the individual or group market that does not provide benefits to individuals who no longer live or work in a service area, loss of coverage because the individual no longer lives or works in the service area (whether or not within the choice of the individual) and, in the case of group coverage, no other benefit package is available.

(3) If a Retiree and/or Dependent Spouse enrolled in the Plan and subsequently terminated coverage under the Fund:

(a) If the other coverage was the Affordable Care Act Health Insurance Marketplace, state exchange or employer or trust fund Medicare Advantage contract, the Retiree and/or Spouse may reenroll in this Plan within 31 days of the date the other health coverage ceases.

(b) If the other coverage was an employer's health plan, the Retiree and/or Spouse may reenroll in this Plan within 31 days of the date the other health coverage ceases, if that other coverage terminated due to:

(i) The loss of eligibility for the other coverage as a result of termination of employment, reduction in the number of hours of employment, or death, divorce or legal separation;

(ii) The termination of employer contributions toward the other coverage.

(4) In all cases of Late Enrollment, in order for a Dependent to enroll in the Plan, the Retiree must also be enrolled, except in the case of a surviving Spouse.

d. **Termination of Eligibility.**

(1) A Retiree's eligibility will terminate on the last day of any calendar month for which the Retiree fails to satisfy the requirements of SECTION 2.01.a.

(2) The date the Retiree ceases making self-payments required for coverage.

(3) The eligibility of a Dependent of a Retiree will terminate on the earliest of the following dates:

(a) On the date the Retiree's eligibility terminates;

(b) On the date he or she no longer qualifies as a Dependent, except that eligibility for Dependent natural children, stepchildren and legally adopted children will terminate at the end of the month in which the Dependent turns age 26; or

(c) the date the Retiree ceases making the self-payments required for Dependent coverage.

(4) A Dependent child 19 years of age or older whose eligibility is based on student status will continue to be eligible during a Medically Necessary leave of absence from school, subject to the following:

(a) Eligibility will continue for up to 12 months or until eligibility would otherwise terminate under the Fund's eligibility rules, whichever comes first.

(b) Eligibility will terminate before 12 months on the date the Medical Necessity for the leave no longer exists.

(c) The Dependent or Participant must submit documentation to the Fund Office, including a Physician's certification of the medical necessity for the leave. The certification form must be submitted to the Fund Office at least 30 days prior to the medical leave of absence if it is foreseeable, or 30 days after the start of the leave of absence in any other case.

(d) If eligibility is extended under this provision for a child who is no longer eligible for tax-free health coverage, the Participant parent of the Dependent may be required to certify in writing to the Fund as to the child's tax status.

(5) In the event of the Retiree's death, his/her surviving legal Spouse will be given a one-time only opportunity to continue coverage under one of the following 3 options:

(a) In the event of the death of a Retiree, other than one receiving a Disability pension, (including one receiving a Joint and Survivor Pension) who received pension benefits for less than 60 months, the eligibility of the legal Spouse and Dependent children, if any, will continue for the remainder of the 60 month period, provided the applicable self-payment is made, unless the Spouse remarries prior to the termination of pension payments, at which time coverage terminates; or

(b) In the event of the death of a Retiree who received a Disability Pension or a Reciprocal Disability Pension, (including one receiving a Joint and Survivor Pension), who received pension benefits for less than 36 months, the legal Spouse and eligible Dependent children may continue to be eligible for the remainder of the 36 month period provided the required self-payment is made, unless the Spouse remarries prior to the termination of pension payments, at which time coverage terminates; or

(c) In the event of the death of a Retiree who was receiving a Joint and Survivor Pension, a surviving Spouse may continue eligibility for herself only, provided the applicable self-payment is made and provided the surviving legal Spouse is receiving a monthly pension benefit.

(6) A Retiree, not Eligible for Medicare, who was covered under the Plan prior to June 1, 1995, may elect to terminate coverage. Upon attaining eligibility for Medicare benefits, the Retiree may re-enroll in the Plan in accordance with SECTION 2.01.c.

e. **Engagement in Employment.**

(1) A Retiree who returned to employment with a Contributing Employer during the period from July 1, 1998, through December 31, 1998, will continue to be eligible under the Plan as a Retiree. Any self-payments normally required for Retiree health and welfare coverage will

be waived for each month in which the Retiree works the minimum number of hours that would otherwise qualify him for eligibility under the Active Employees' Plan.

(2) The provisions of the above Subsection e.(1) will also apply to any Retiree who returned to employment with a Contributing Employer during the period April 1, 2001, through March 31, 2002.

(3) Engagement in Employment After June 1, 2009. A Retiree who is receiving benefit payments from the Carpenters Pension Trust Fund for Northern California, who engages in a type of work beginning June 1, 2009, that requires Active contributions to this Fund but does not result in the suspension of benefit payments from the Carpenters Pension Trust Fund for Northern California will not establish eligibility under this Plan.

However, if the Retired Employee works enough consecutive hours such that, in the absence of this rule, he/she would normally qualify for eligibility as an active Employee, 50% of the health and welfare contributions remitted to this Plan on the Retired Employee's behalf will be used to offset his/her self-pay contributions for Retiree health coverage. Such offset will only be granted for 50% of the contributions on up to a maximum of 480 hours in a calendar year.

If the individual is not an eligible Retired Employee in this Plan, or if the hours worked are less than the number required to earn eligibility under the Active Employees' Plan in the absence of this rule, no health and welfare contributions will be credited on the individual's behalf.

SECTION 2.02. Continuation Coverage Under COBRA. COBRA requires that under specific circumstances when coverage terminates, certain health plan benefits available to the Dependents of a Retiree must be offered for extension through self-payments. To the extent that COBRA applies to any Dependent under this Plan, these required benefits will be offered in accordance with this SECTION 2.02.

a. **General.** Dependents who lose eligibility under the Plan may continue Plan coverage subject to the terms of this SECTION 2.02. This Article is intended to comply with the health care continuation provisions of COBRA. Those provisions are incorporated by reference in the Plan and will be controlling in the event of any conflict between those provisions and the terms of this Section.

b. **Continuation Coverage.** Dependents of Retirees whose eligibility terminates may continue coverage under COBRA upon the occurrence of a Qualifying Event.

A Qualifying Event is defined as any of the following:

(1) The Retiree's death;

(2) Divorce of the Retiree from his/her Dependent Spouse;

(3) Cessation of a Dependent child's Dependent status.

c. **Qualified Beneficiary.** A Qualified Beneficiary as defined under COBRA is an individual who loses coverage under any of the above referenced Qualifying Events. A child born to, or placed for adoption with, a Retiree during a period of COBRA Continuation Coverage will be a Qualified Beneficiary.

d. **Addition of New Dependents.**

(1) If, while enrolled for COBRA Continuation Coverage, a Qualified Beneficiary marries, has a newborn child, has a child placed for adoption or assumes legal guardianship of a child, he or

she may enroll the new Spouse or child for coverage for the balance of the period of COBRA Continuation Coverage by doing so within 30 days after the birth, marriage or placement for adoption. Adding a child or Spouse may cause an increase in the amount that must be paid for COBRA Continuation Coverage.

(2) Any Qualified Beneficiary may add a new Spouse or child to his or her COBRA Continuation Coverage. The only newly added family members who have the rights of a Qualified Beneficiary are the natural or adopted children of the Retiree or children for whom the Retiree is legal guardian.

e. **Duration of Coverage.** A Qualified Beneficiary whose coverage would otherwise terminate because of a Qualifying Event may elect continuation coverage for up to 36 months from the date of the Qualifying Event.

The 36 months of continuation coverage provided by this paragraph e. will be offset by any extended coverage provided under SECTION 2.01.d.(5).

Notwithstanding the maximum duration of coverage described in the above paragraphs, a Qualified Beneficiary's continuation coverage will end on the earlier of the date on which:

(1) The Plan ceases to provide group health coverage to any covered Retirees;

(2) The premium described in Subsection h. of this SECTION 2.02 is not timely paid;

(3) The Qualified Beneficiary first obtains health coverage, after the date of his/her COBRA election, under another Group Plan which does not exclude or limit any pre-existing condition of the Qualified Beneficiary; or

(4) The Qualified Beneficiary becomes entitled to Medicare benefits after the date he or she elected COBRA Continuation Coverage. Entitled to Medicare benefits means being enrolled in either Part A or Part B of Medicare, whichever occurs earlier.

f. **Election Procedure.** A Qualified Beneficiary must elect continuation coverage within 60 days after the later of:

(1) The date of the Qualifying Event; or

(2) The date of the notice from the Plan Office notifying the Qualified Beneficiary of his/her right to COBRA Continuation Coverage.

Any election by a Qualified Beneficiary who is a Dependent Spouse with respect to continuation coverage for any other Qualified Beneficiary who would lose coverage under the Rules and Regulations of the Plan as a result of the Qualifying Event will be binding. However, each individual who is a Qualified Beneficiary with respect to the Qualifying Event has an independent right to elect COBRA coverage. The failure to elect continuation coverage by a Dependent Spouse will result in any other Qualified Beneficiary being given a 60-day period to elect or reject COBRA coverage.

g. **Types of Benefits Provided.** A Qualified Beneficiary will be provided coverage under these Rules and Regulations which, as of the time the coverage is being provided, is identical to the coverage that is provided to similarly situated Dependents of Retirees with respect to whom a Qualifying Event has not occurred. A Qualified Beneficiary will have the option of taking "core coverage" only. "Core coverage" refers to the health benefits the Qualified Beneficiary was receiving immediately before the Qualifying Event, *excluding* vision benefits.

h. **Premiums.**

(1) A premium for continuation coverage will be charged to Qualified Beneficiaries in amounts established by the Board of Trustees. The premium will be payable in monthly installments.

(2) Any premium due for coverage during the period before the election was made must be paid within 45 days of the date the Qualified Beneficiary elects continuation coverage.

(3) After the initial premium payment, monthly premium payments must be made no later than the first day of the month for which continuation coverage is elected. There is a grace period of 30 days to pay the monthly premium payments. If payment of the amount due is not made by the end of the applicable grace period, COBRA Continuation Coverage will terminate. The Board of Trustees may extend the premium payment due date.

i. **Notice Requirements for Qualified Beneficiaries.**

(1) A Qualified Beneficiary must notify the Fund Office in writing of any Qualifying Event no later than 60 days after the later of the date of the Qualifying Event or the date the Qualified Beneficiary would lose coverage as a result of the Qualifying Event.

(2) The written notice must contain the following information: name of Qualified Beneficiary, Retired Employee's name and identification number, the nature of the Qualifying Event for which notice is being given, date of the Qualifying Event, copy of the final marital dissolution if the event is a divorce.

(3) Notice may be provided by the Retired Employee, Qualified Beneficiary with respect to the Qualifying Event or any representative acting on behalf of the Retired Employee or Qualified Beneficiary. Notice from one individual will satisfy the notice requirement for all related Qualified Beneficiaries affected by the same Qualifying Event.

(4) Failure to provide the Fund Office with written notice of the occurrences described in Subsection (1) above, and within the required time frame, will prevent the individual from obtaining COBRA Continuation Coverage.

j. **Notice Requirements for the Fund.**

(1) No later than 60 days after the date on which the Fund Office receives written notification from the Qualified Beneficiary, the Fund Office will notify the Qualified Beneficiary in writing of his or her rights to continuation coverage.

(2) The Plan's written notification to a Qualified Beneficiary who is a Dependent Spouse will be treated as notification to all other Qualified Beneficiaries residing with that person at the time the notification is made.

(3) It is the responsibility of a Qualified Beneficiary to notify the Fund Office of any change in address.

k. **Additional COBRA Election Period in Cases of Eligibility for Benefits Under the Trade Act Amendments of 2002.** An individual who is certified by the U.S. Department of Labor (DOL) as eligible for benefits under the Trade Act Amendments of 2002 may be eligible for a new opportunity to elect COBRA. Qualified Beneficiaries who did not elect COBRA during their election period but are later certified by the DOL for Trade Act benefits, or who receive a pension managed by the Pension Benefit Guaranty Corporation (PBGC), may be entitled to an additional 60-day COBRA election period beginning on the first day of the month in which they were certified. However, in no event would this benefit allow a person to elect COBRA later than 6 months after his or her coverage ended under the Plan.

SECTION 2.03. Election of Coverage.

a. Each Retiree who becomes eligible will have the opportunity to elect medical and prescription drug coverage provided directly by the Fund, as described in these Rules and Regulations, or the coverage then being offered through any prepaid medical plan offered by the Fund. A Retiree must live within the service area of the prepaid plan to enroll in that plan. The coverage selected by the Retiree will apply to any eligible Dependents of the Retiree.

b. Changes in Coverage. Retirees and their Dependents must remain in the plan selected for a minimum of 12 months, unless the Retiree moves out of the prepaid plan's service area or a change is approved by the Board of Trustees. Any change in plans will be effective on the later of the first day of the second calendar month following the date the enrollment form is received by the Fund, or the date a prepaid plan confirms enrollment in or disenrollment from a Medicare Risk plan.

ARTICLE 3. INDEMNITY MEDICAL PLAN BENEFITS FOR RETIREES AND DEPENDENTS NOT ELIGIBLE FOR MEDICARE

The benefits described in this Article are payable for Covered Expenses incurred by an Eligible Individual for Medically Necessary treatment of a non-occupational Illness or Injury and preventive services specifically covered by the Plan. An expense is incurred on the date the Eligible Individual receives the service or supply for which the charge is made. These benefits are subject to all provisions of the Plan that may limit benefits or result in benefits not being payable.

SECTION 3.01. Deductible. The Plan will not begin paying Indemnity Medical Plan benefits until the Eligible Individual or family has satisfied the Deductible amount for the calendar year, as specified below for Contract and Non-Contract Providers. Only Covered Expenses are applied to the Deductible. Amounts not payable due to failure to comply with the Plan's Utilization Review Program or amounts exceeding any Plan limits on specific benefits are not applied to the Deductible.

a. Deductible amount per calendar year for:

   (1) Contract Providers – $128 per person, not to exceed $256 per family.

   (2) Non-Contract Providers – $257 per person, not to exceed $514 per family.

b. Any amounts applied to the Deductible for Contract Providers will also count toward the Non-Contract Provider Deductible, and any amounts applied to the Non-Contract Provider deductible will also count toward the Contract Provider Deductible amount.

c. Only amounts that have been applied to an individual's per person Deductible will apply to the family Deductible amount.

d. Exceptions to the Non-Contract Provider Deductible. The Deductible for Contract Providers will apply to the Non-Contract Provider services outlined in SECTION 3.02.c.(2) and (5) below.

e. The Deductible does not apply to Contract Provider on-line physician visits, provided the charge does not exceed $59 per visit.

f. For the duration of the Public Health Emergency, the Deductible does not apply to screening services for COVID-19 Contract Provider Allowed Amounts or to the cash price listed on the public website (or, if lower, the negotiated rate) for laboratory screening by a Non-Contract Provider. This includes items and services given during office, urgent care, telehealth and emergency room visits in relation to the evaluation or furnishing of the test.

g. The Deductible does not apply to COVID-19 vaccines when received from a Contract Provider or Non-Contract Provider, including a Participating or Non-Participating Pharmacy. After the Public Health Emergency ends, the Plan will continue to cover COVID-19 vaccines at 100% with no deductible when received from a Contract provider (including a pharmacy), but it will no longer be covered from Non-Contract providers.

h. The Deductible does not apply to women's preventive care services as described in subsections 3.05.a. and 3.05.d. or certain vaccines and immunizations as described in subsection 3.05.e.

SECTION 3.02. Payment. Except as otherwise stated in Subsection c. below, and until the Annual Out of Pocket Maximum described in SECTION 3.03 is met, all benefits for Covered Expenses are payable as follows, subject to SECTION 3.01:

a. Contract Providers – 90% of the negotiated contract rate.

b. Non-Contract Providers – 70% of the Allowed Charge.

c. Exceptions to payment percentages specified in Subsections a. and b:

(1) Substance Abuse Treatment. Contract Provider: 100% of contracted rates for the first course of treatment and 90% of contracted rates for subsequent courses of treatment. Non-Contract Provider: 70% of Allowed Charge.

(2) Contract Provider On-line physician visits. Benefits are payable in accordance with SECTION 3.06.k.

(3) Certain Contract Provider preventive benefits payable at 100% (no deductible or coinsurance). The benefit payable for women's preventive services as described in subsections 3.05.a. and 3.05.d. as well as the vaccines and immunizations as described in subsection 3.05.e. when received from a Contract Provider.

(4) For the duration of the Public Health Emergency, the benefit payable for laboratory screening services for COVID-19 is 100% of the Contract Provider Allowed Amount or 100% of the cash price listed on the public website (or, if lower, the negotiated rate) for laboratory screening by a Non-Contract Provider. This includes items and services given during an office, urgent care, telehealth, or emergency room visit to the extent they related to the evaluation or furnishing of the test.

(5) Exceptions to Non-Contract Provider Payment.

(a) If a Non-Contract anesthesiologist or emergency room Physician provides services at a Contract Hospital or Contract Facility, the benefit payable is 90% of the Allowed Charge.

(b) The benefit payable for Non-Contract Provider licensed ambulance service is 90% of the Allowed Charge.

(c) If the service provided is Medically Necessary and not available from a Contract Provider, the benefit payable is 90% of the Allowed Charge.

(d) The benefit payable for COVID-19 vaccines is 100% of the Contract Provider Allowed Amount or, for the duration of the Public Health Emergency only, 100% of the average Contract Allowed Amount for services by a Non-Contract Provider.

(e) Emergency Services in a Non-Contract Hospital are covered at 90% of Allowed Charges:

i. Without the need for any prior authorization determination, even if the services are provided on a Non-Contract basis;

ii. Without regard to whether the health care provider furnishing the Emergency Services is a Contract Provider or a Contract emergency facility, as applicable, with respect to the services;

iii. If the emergency services are provided by a Non-Contract Provider or a Non-Contract emergency facility:

a. Without imposing any administrative requirement or limitation on Non-Contract Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from Contract Providers and Contract emergency facilities;

b. Without imposing Cost-sharing requirements on Non-Contract Emergency Services that are greater than the requirements that would apply if the services were provided by a Contract Provider or a Contract emergency facility;

c. By calculating the Cost-sharing requirement for Non-Contract Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services; and

d. By counting any Cost-sharing payments made by the Participant or Dependent with respect to the Emergency Services toward any Contract Deductible or Contract out-of-pocket maximums applied under the Plan (and the Contract Deductible and Contract out-of-pocket maximums are applied) in the same manner as if the Cost-sharing payments were made with respect to Emergency Services furnished by a Contract Provider or a Contract emergency facility.

iv. Emergency Services furnished by a Non-Contract Provider or Non-Contract emergency facility (regardless of the department of the hospital in which such items or services are furnished) also includes post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the Emergency Medical Condition are covered, until:

a. The provider or facility determines that the Participant or Dependent is able to travel using nonmedical transportation or nonemergency medical transportation; and

b. The Participant or Dependent is supplied with a written notice, as required by federal law, that the provider is a Non-Contract Provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any Contract Providers at the facility who are able to treat you, and that you may elect to be referred to one of the Contract Providers listed; and

c. The Participant or Dependent is in a condition to receive the written notice, as determined by the attending emergency physician or treating provider using appropriate medical judgment, and to provide informed consent under such section, in accordance with applicable state law.

d. The Participant or Dependent gives informed consent to continued treatment that is not considered Emergency Services by the Non-Contract Provider, acknowledging that the Participant or Dependent understands that continued treatment by the Non-Contract Provider

may result in greater cost to the Participant or Dependent and balance billing.

v. With regard to non-emergency items or services that are otherwise covered by the Plan, if the covered non-emergency items or services are performed by a Non-Contract Provider at a Contract facility, the items or services are covered by the plan:

   a. With a Cost-sharing requirement that is no greater than the Cost-sharing requirement that would apply if the items or services had been furnished by a Contract Provider,

   b. By calculating the Cost-sharing requirements as if the total amount that would have been charged for the items and services by such Contract Provider were equal to the Recognized Amount for the items and services.

   c. By counting any Cost-sharing payments made by the Participant or Dependent toward any Contract Deductible and Contract out-of-pocket maximums applied under the plan (and the Contract Deductible and Out-of-Pocket maximums must be applied) in the same manner as if such Cost-sharing payments were made with respect to items and services furnished by a Contract Provider.

vi. Non-emergency items or services performed by a Non-Contract Provider at a Contract facility will be covered based on your out-of-network coverage if:

   a. At least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), the Participant or Dependent is supplied with a written notice, as required by federal law, that the provider is a Non-Contract Provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment; and

   b. The Participant or Dependent gives informed consent to continued treatment by the Non-Contract Provider, acknowledging that the Participant or Dependent understands that continued treatment by the Non-Contract Provider may result in greater cost to the Participant or Dependent, that the payment of such charge might not accrue toward meeting any limitation of the plan on Cost-sharing (such as Deductible or out-of-pocket maximum), and that the Participant or Dependent may be balance billed.

vii. The notice and consent exception does not apply to Ancillary Services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Non-Contract Provider satisfied the notice and consent criteria, and therefore these services will be covered

   a. With a Cost-sharing requirement that is no greater than the Cost-sharing

requirement that would apply if the items or services had been furnished by a Contract Provider,

b. With Cost-sharing requirements calculated as if the total amount charged for the items and services by such Contract Provider were equal to the Recognized Amount for the items and services, and

c. With Cost-sharing counted toward any Contract deductible and Contract out of pocket maximums, as if such Cost-sharing payments were with respect to items and services furnished by a Contract Provider.

viii. However, for inpatient confinements, the Plan may require that the Patient transfer to a Contract Hospital upon the advice of a Physician that it is medically safe to transfer the Patient and the acute Emergency period has ended. If the Patient remains in the Non-Contract Hospital after the acute Emergency period, the benefit payable will be **70%** of the Allowed Charge for the period of confinement after the Emergency period has ended.

(6) **Continuing Care.** If a Participant or Dependent is a Continuing Care Patient, and the contract with provider or facility terminates, or benefits under a group health plan are terminated because of a change in terms of the providers' and/or facilities' participation in the plan:

(a) The Participant or Dependent will be notified in a timely manner of the contract termination and of the right to elect continued transitional care from the provider or facility; and

(b) The Participant or Dependent will be allowed continued coverage at Contract Cost sharing to allow for a transition of care to a Contract Provider until the earlier of a) ninety (90) days or b) the date on which such the Participant or Dependent is no longer considered a Continuing Care Patient with respect to that provider.

SECTION 3.03. Annual Out of Pocket Maximum. Each calendar year, after an Eligible Individual or family incurs the maximum out of pocket cost for Covered Expenses as specified below in Subsection a., the Plan will pay 100% of Covered Expenses incurred during the remainder of that calendar year. Only Covered Expenses will be applied to the out of pocket maximum. Amounts not payable due to failure to comply with the Plan's pre-authorization requirements or amounts exceeding any Plan benefit limits or maximums will not be applied to the out of pocket maximum.

a. The Annual Out of Pocket Maximum for Contract Providers is $1,289 per person, not to exceed $2,578 per family.

b. There is no Annual Out of Pocket Maximum for Non-Contract Provider charges.

c. The following expenses will not count toward the Out-of-Pocket maximum and will not be payable at 100% after the Out-of-Pocket maximum is reached:

(1) Amounts applied to the deductible.

(2) Any amounts exceeding the Plan limits for specific benefits, including the Plan limits for the following benefits: Acupuncture, chiropractic services, hearing aids, Non-Contract ambulatory surgery facilities, inpatient and outpatient Hospital facility services associated with single hip joint replacement or single knee joint replacement surgery, and specified surgical procedures performed in an outpatient Hospital setting.

(3) Any amount not covered due to failure to comply with the Plan's Utilization Review Program.

SECTION 3.04. Hospital and Facility Benefits.

a. Inpatient Services

(1) Utilization Review Requirement. If an Eligible Individual is to be confined in a Hospital or inpatient treatment Facility, the Physician or Hospital/Facility must obtain Pre-Admission Review by the Professional Review Organization (PRO) to determine the Medical Necessity of the Hospital or Facility confinement, and if Medically Necessary, the number of authorized days determined to be Medically Necessary for the confinement. Pre-Admission Review must be obtained prior to a non-emergency Hospital or Facility confinement. In the case of an emergency confinement, the Hospital/Facility or Physician must contact the PRO within 24 hours after admission. If Utilization Review is not obtained prior to admission or retroactively, benefits will be denied under SECTION 7.01.b.

(2) Benefits are payable for charges made by the Hospital for room and board, operating rooms, Drugs, medical supplies and services provided during the confinement, including any professional component of the services, including the following:

(a) In a Non-Contract Hospital, a room with 2 or more beds, or the minimum charge for a 2-bed room in the Hospital if a higher priced room is used, or intensive care units when Medically Necessary. In a Contract Hospital, the contract rate is covered.

(b) In a Contract Hospital only, take home Drugs dispensed by the Hospital's pharmacy at the time of the Eligible Individual's discharge.

(c) In a Contract Hospital only, blood transfusions including the cost of unreplaced blood, blood products and blood processing. In a Non-Contract Hospital, blood transfusions but not the cost of blood, blood products and blood processing.

(d) In a Contract Hospital only, transportation services during a covered inpatient stay.

(e) In a Contract Hospital only, routine newborn nursery charges.

(3) A maximum of $35,000 is payable for Hospital inpatient facility services associated with a single hip joint replacement or a single knee joint replacement surgery.

b. Outpatient Hospital, Urgent Care Facility, provided that surgical facility services are in connection with surgery that is covered by the Plan. If an Eligible Individual needs one of the following outpatient surgical procedures, the Physician or Hospital/Facility must obtain Pre-Admission Review by the Professional Review Organization (PRO) to determine the Medical Necessity of the surgery. Pre-Admission Review must be obtained prior to the following surgical procedures.

The maximum payable benefit listed below will apply to the following procedures when received in an outpatient Hospital setting:

(1) Colonoscopy - $1,500

(2) Arthroscopy - $6,000

(3) Cataract surgery - $2,000

(4) All other Endoscopies - $1,000

(5) Laparoscopic gall bladder - removal - $5,000

(6) Hysteroscopy uterine tissue sample (with biopsy, with or without dilation and curettage) - $3,500

(7) Nasal/Sinus - submucous resection inferior turbinate services - $3,000

(8) Tonsillectomy and/or adenoidectomy (for a Member under age 12) - $3,000

(9) Nasal/sinus - corrective surgery – septoplasty - $3,500

(10) Lithotripsy - $7,000

(11) Hernia inguinal repair (over age 5, non-laparoscopic) - $4,000

(12) Esophagoscopy - $2,000

(13) Repair of laparoscopic inguinal hernia - $5,500

(14) Sigmoidoscopy - $1,000

(15) Upper gastrointestinal endoscopy without biopsy - $1,500

(16) Upper gastrointestinal endoscopy with biopsy - $2,000

(17) Single Knee Replacement - $35,000

(18) Single Hip Replacement - $35,000

In the following situations only, the Board has discretion to make an exception to the maximum payable benefits:

(a) Your access to a provider, hospital or outpatient surgery center that will accept the maximum allowable charge is unavailable or the service cannot be obtained within a reasonable wait time or travel distance; and

(b) The quality of services for you or your Dependents could be compromised with the provider, hospital or outpatient surgery center (e.g., if comorbidities present complications or patient safety issues).

c. Licensed Ambulatory Surgical Facility, provided that surgical facility services are in connection with surgery that is covered by the Plan. There is a daily maximum benefit of $300 for all services received at a Non-Contract Ambulatory Surgical Facility.

d. Skilled Nursing Facility. Benefits are provided up to a maximum of 70 days per Period of Confinement in a Skilled Nursing Facility, subject to the following:

(1) Services must be those which are regularly provided and billed by a Skilled Nursing Facility.

(2) The services must be consistent with the Illness, Injury, degree of disability and medical needs of the Eligible Individual, as determined by the PRO. Benefits are provided only for the number of days required to treat the Eligible Individual’s Illness or Injury.

(3) The Eligible Individual must remain under the active medical supervision of a Physician. The Physician must be treating the Illness or Injury for which the Eligible Individual is confined in the Skilled Nursing Facility.

(4) A new Period of Confinement will begin after 90 days have elapsed since the last confinement in a Skilled Nursing Facility.

SECTION 3.05. Preventive Care Benefits

a. Routine Mammogram Benefit. Benefits are payable at the percentages described in SECTION 3.02. for a mammogram obtained as a diagnostic screening procedure, including digital mammography. Benefits are payable in accordance with the following schedule:

(1) For women age 35 through 39 – one baseline mammogram.

(2) For women age 40 and over – one mammogram every year.

b. Routine Physical Examination Benefit – Benefits are payable at the percentages described in SECTION 3.02. for routine physical examinations. This benefit includes all laboratory tests and x-rays provided as part of the physical examination. For newborn children, this benefit includes Physician visits in the Hospital and Physician standby charges during a cesarean section, but not well-baby Hospital nursery charges (except for nursery charges from a Contract Hospital, see Exclusion in SECTION 7.01.g.). Routine Physical Exam benefits are limited to one routine physical examination in any 12-month period for the Participant and Spouse.

c. Colonoscopy / Sigmoidoscopy. The Fund will pay benefits at the percentages described in SECTION 3.02. for colonoscopy and sigmoidoscopy examinations received by Retirees and Dependent Spouses who are considered at high risk for colon cancer, when recommended by a Physician. There is a maximum payable benefit of $1,500 for a colonoscopy received in an outpatient Hospital setting.

d. Routine Ob/Gyn Exam Benefit. Benefits are payable at the percentages described in SECTION 3.02. for a routine OB/GYN examination provided by a Physician. Benefits are limited to one routine physical examination in any 12-month period for the Participant and Spouse only. Coverage includes any x-rays and laboratory tests provided in connection with the physical examination, including pap smears.

e. The following vaccines and immunizations received with a Contracted provider will be covered at 100% (no deductible or coinsurance):

(1) Immunization vaccines for adults—doses, recommended ages and recommended populations must be satisfied:

(a) Diphtheria/tetanus/pertussis

(b) Measles/mumps/rubella (MMR)

(c) Influenza

(d) Human papillomavirus (HPV)

(e) Pneumococcal (polysaccharide)

(f) Zoster

(g) Hepatitis A

(h) Hepatitis B

(i) Meningococcal

(j) Varicella

(k) COVID-19

(2) Immunization vaccines for children from birth to age 18—doses, recommended ages and recommended populations must be satisfied:

(a) Hepatitis B

(b) Rotavirus

(c) Diphtheria/tetanus/pertussis

(d) Haemophilus influenzae type b

(e) Pneumococcal

(f) Inactivated Poliovirus

(g) Influenza

(h) Measles, Mumps, Rubella

(i) Varicella

(j) Hepatitis A

(k) Meningococcal

(l) Human papillomavirus (HPV)

(m) COVID-19

SECTION 3.06. Covered Professional Services.

a. Services of a Physician.

b. Services of a registered nurse, including:

(1) Services of a certified nurse midwife for obstetrical care during the prenatal, delivery and postpartum periods provided he or she is practicing under the direction and supervision of a Physician.

(2) Services of a licensed nurse practitioner, provided he or she is acting within the lawful scope of his/her license, the services are in lieu of the services of a Physician and the provider is performing services under the supervision of a duly licensed Physician, if supervision is required.

c. Services of a licensed Physician Assistant, provided the services are performed under the supervision of a Physician, and subject to the following requirements:

(1) Covered services are limited to assistant-at-surgery, physical examinations, administering injections, minor setting of casts for simple fractures, interpreting x-rays and changing dressings.

(2) Services of the Physician Assistant must be billed under the tax identification number of the

supervising Physician.

(3) Services must be of the type that would be considered Physician services if provided by an M.D. or D.O.

(4) For Non-Contract Providers only, Covered Expenses are limited as follows:

(i) For assistant-at-surgery services, 85% of the amount that otherwise would be allowed if the services were performed by a Physician serving as an assistant-at-surgery, or

(ii) For other covered services, 85% of the applicable Physician's Allowed Charge for services performed.

(5) For Contract Providers, Covered Expenses are limited to the Contract Provider negotiated rate.

d. Contraception Related Services. Professional outpatient services related to contraception are covered on the same basis as other professional services, including but not limited to services in connection with obtaining or removing a prescription contraceptive device or implant.

e. Services of a registered physical therapist provided the services are within standard medical practices and are prescribed by a Physician. Covered services do not include those services which are primarily educational, sports related or preventive, such as physical conditioning, "back school" or exercise.

f. Services of a Podiatrist.

g. Services of a licensed speech therapist, but only for speech therapy that is provided to an Eligible Individual who had normal speech at one time and lost it due to an Illness or Injury or as part of an approved autism therapy plan.

h. Services of a licensed optometrist, but only when providing Medically Necessary medical treatment to the eye that is not covered by the vision plan administered by Vision Service Plan.

i. Acupuncture treatment provided by a licensed acupuncturist, subject to the following limitations:

(1) The amount paid by the Plan will not exceed a maximum payment of $35 per visit.

(2) Benefits are limited to 20 visits per calendar year.

j. Chiropractic services provided to a Participant or Dependent Spouse by a licensed Chiropractor, subject to the following limitations:

(1) The amount paid by the Plan will not exceed a maximum payment of $25 per visit.

(2) Benefits are limited to 20 visits per calendar year.

(3) No benefits are payable for chiropractic services provided to Dependent children.

k. On-line physician visits: LiveHealth Online visits provided to a Participant or Dependent will be payable at 100% if provided by a LiveHealth Online physician or other LiveHealth medical professional.

l. On-line physician visits by a Contract Provider.

SECTION 3.07. Additional Covered Services and Supplies.

a. Licensed ambulance services for ground transportation to or from the nearest Hospital. Allowed Charges of a licensed air ambulance to or from the nearest Hospital are covered if the location and nature of the Illness or Injury made air transportation cost effective or necessary to avoid the possibility of serious complications or loss of life. Services provided by an Emergency Medical Technician (EMT) without subsequent emergency transport are paid in accordance with this Ambulance Services benefit.

b. Diagnostic radiology and laboratory services subject to the following limitations:

   (1) Services must be ordered by a Physician, including laboratory tests associated with diagnosing a viral illness.

   (2) For the following outpatient diagnostic imaging services, the Physician must obtain pre-authorization from the Review Organization:

      (a) CT/CTA

      (b) MR/MRI

      (c) Nuclear cardiology

      (d) PET scan

      (e) Echocardiography

c. Radiation therapy and chemotherapy.

d. Artificial limbs or eyes.

e. Medical equipment and supplies. Rental charges are covered if they do not exceed the Plan Allowed Charges or reasonable purchase price of the equipment. Benefits are payable only if the equipment or supply is:

   (1) Ordered by a Physician;

   (2) Of no further use when medical need ends;

   (3) Usable only by the Patient;

   (4) Not primarily for the comfort or hygiene of the Eligible Individual;

   (5) Not for environmental control;

   (6) Not for exercise;

   (7) Manufactured specifically for medical use;

   (8) Approved as effective and usual and customary treatment of a condition as determined by the PRO; and

   (9) Not for prevention purposes.

f. Contraceptive devices and implants that legally require the prescription of a Physician.

g. Blood transfusions, including blood processing and the cost of unreplaced blood and blood products. Self-donated blood, limited to the Allowed Charges that would be charged if the blood were obtained from a blood bank.

h. Dental Injury. Services of a Physician (M.D.) or Dentist (D.D.S.) treating an Injury to natural teeth. Services must be received within 6 months following the date of Injury (applied without respect to when the individual was enrolled in the Plan). Damage to teeth due to chewing or biting is not covered under this benefit.

i. Organ Transplants. The Fund will cover Covered Expenses incurred by the organ donor and the organ recipient when the organ recipient is an Eligible Individual. Covered Expenses in connection with the organ transplant include patient screening, organ procurement and transportation of the organ, surgery and Hospital charges for the recipient and donor, follow-up care in the home or a Hospital and immunosuppressant Drugs, subject to the following conditions and limitations:

(1) The transplantation is not considered an Experimental or Investigative Procedure as that term is described in SECTION 7.01.w.;

(2) Anthem precertification rules are satisfied;

(3) The services provided must be approved by the Fund's PRO;

(4) The recipient of the organ is an Eligible Individual under the Plan; and

(5) Benefits payable for an organ donor who is not an Eligible Individual will be reduced by any amounts paid or payable by that donor's own health coverage.

In no case will the Plan cover expenses for transportation of the donor, surgeons or family members.

j. Home Health Care. Benefits are provided in accordance with Subsections (1) and (2) below:

(1) Covered Expenses include:

(a) Services of a registered nurse.

(b) Services of a licensed therapist for physical therapy, occupational therapy and speech therapy.

(c) Services of a medical social service worker.

(d) Services of a health aide who is employed by (or contracted with) a Home Health Agency. Services must be ordered and supervised by a registered nurse employed by the Home Health Agency as a professional coordinator.

(e) Necessary medical supplies provided by the Home Health Agency.

(2) Conditions of Service:

(a) The Eligible Individual must be confined at home under the active medical supervision of a Physician ordering home health care and treating the Illness or Injury for which that care is needed.

(b) Services must be provided and billed by the Home Health Agency.

(c) Services must be consistent with the Illness, Injury, degree of disability and medical needs of the Patient. Benefits are provided only for the number of days required to treat the Eligible Individual's Illness or Injury.

(d) Allowed Specialty Drugs are provided by the Prescription Drug Benefits and are not covered under this Home Health Care benefit. Please see Article 5 for information on Prescription Drug coverage for injectable, infusion and chemotherapy Drugs.

k. Hospice Care: If an Eligible Individual is terminally ill, with a life expectancy of 6 months or less, benefits are payable for hospice care provided by an Approved Hospice Program. Covered Services must be prescribed by a Physician and will include:

(1) Nursing Services by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.);

(2) Medical Social Services by a person with a Master's degree in social work,

(3) Home health aide, medical supplies normally used by Hospital inpatients and dispensed by the hospice agency,

(4) Nutritional Supplements such as diet substitutes administered intravenously or through hyperalimentation; and

(5) Respite Care, not to exceed 8 days.

Covered benefits will not include transportation, services of volunteers, food, clothing or housing, services provided by household members, family or friends or services of financial or legal counselors.

l. Substance Abuse Treatment. Inpatient treatment is subject to the Pre-admission review by the Utilization Review Program.

(1) Inpatient Treatment, including Residential Treatment. Contract Provider: After deductible, the Fund will pay 100% of contract rates for the first course of treatment and 90% of contract rates for subsequent treatment programs. Non-Contract Provider: After deductible, the Fund will pay 70% of the Allowed Charge.

(2) Outpatient Treatment (in outpatient facilities or for outpatient office visits). Contract Provider: After deductible, the Fund will pay 100% of contract rates for the first course of treatment and 90% of contract rates for subsequent treatment programs. Non-Contract Provider: After deductible, the Fund will pay 70% of the Allowed Charge.

(3) Emergency Room Care. Contract Provider: After deductible, the Fund will pay 90% of the contract rate. Non-Contract Provider: After deductible, the Fund will pay 90% of the Allowed Charge.

m. Diabetes Instruction Programs, provided the program is recognized as an acceptable program by the American Diabetes Association.

n. Mental Health Treatment. Inpatient treatment is subject to Pre-admission review by the Utilization Review Program. All benefits are paid the same as inpatient and outpatient medical treatment under the Plan.

o. Non-Contract Providers who are not registered with Centers for Medicare & Medicaid Services (CMS) who provide out-patient services, subject to the following limitations:

   (1) Services must be Medically Necessary.

   (2) The amount allowed by the Plan will not exceed a maximum of $200 per appointment.

p. Hearing examination performed by a Physician or person with a master's or doctoral degree in audiology, when ordered by a Physician.

q. Breast Pump rental or purchase for females who are breastfeeding. A manual or electric breast pump is covered by the Plan up to a maximum benefit of **$75 per calendar year**.

r. The following Specialty Drugs may be covered under either the Indemnity Medical Plan benefit or the Prescription Drug benefit. If filled under the Indemnity Medical Plan benefit, it will be subject to the cost-sharing specified in SECTION 3.02., and require prior authorization.

Brand	Generic
Zirabev or Mvasi	bevacizumab
Uplizno	ipilimumab
Keytruda	pembrolizumab
Herceptin	trastuzumab
Rituxan	rituximab
Prolia or Xgeva	denosumab
Opdivo	nivolumab
Lupron	leuprorelin

s. Smoking Cessation: Covered benefits include counseling and interventions for tobacco use (both smoking and chewing tobacco) as follows:

   i. screening for tobacco use; and,

   ii. for tobacco users, at least two (2) tobacco cessation attempts per year. Each "tobacco cessation attempt" includes coverage for **four (4) tobacco cessation counseling sessions** of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and all **FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications)** for a 90-day treatment regimen when prescribed by a Contracted health care provider.

SECTION 3.08. Extension of Benefits Upon Termination. An Eligible Individual who is receiving Plan benefits for inpatient Hospital or Skilled Nursing Facility care, or for services of a Home Health Agency, on the date coverage ends due to loss of eligibility, will continue to receive benefits for that care until the Individual is discharged from the Hospital or Skilled Nursing Facility, or completes the covered home health care.

ARTICLE 4. HEARING AID BENEFITS FOR MEDICARE AND NON-MEDICARE ELIGIBLE INDIVIDUALS

SECTION 4.01. Upon certification by a Physician that an Eligible Individual has a hearing loss, and that the loss may be lessened by the use of a hearing aid, the Fund will, subject to the provisions of the Plan, pay 100% of the Allowed Charges incurred, up to a maximum payment of $800 per ear, for the hearing aid and any repairs and servicing. This is the maximum benefit payable in any 3-year period for all expenses related to hearing aids.

SECTION 4.02. Exclusions. No benefits will be provided for:

a. The replacement of a hearing aid for any reason more often than once during any 3-year period;

b. Batteries or any other ancillary equipment other than that obtained upon the purchase of the hearing aid;

c. Expenses incurred for which the individual is not required to pay;

d. Hearing aids for participants enrolled in the Kaiser Foundation Health Plan.

ARTICLE 5. PRESCRIPTION DRUG BENEFITS FOR NON-MEDICARE ELIGIBLE INDIVIDUALS

SECTION 5.01. Benefits. If prescription medicines (or insulin) are prescribed by a Physician and dispensed by a Participating Pharmacy for an Eligible Individual, the Fund will pay the Covered Expenses incurred after the Eligible Individual pays the required Copayment specified below (please note certain drugs are not covered and/or need prior authorization):

a. Retail Pharmacy, for each 30-day supply, the Copayment is:

(1) Formulary Generic Drug - $15.

(2) Multi-Source Brand Name Drug - $15 plus the difference in cost between the generic and brand name Drugs.

(3) Single Source Formulary Brand Name Drug - $53.

(4) Non-Formulary Drug - $80, provided the Drug has been prior authorized or does not require prior authorization.

b. Mail Order Pharmacy or Walgreen's Pharmacy, for each 90-day supply, the Copayment is:

(1) Formulary Generic Drug - $26

(2) Multi-Source Brand Name Drug - $26 plus the difference in cost between the generic and brand name Drugs

(3) Single Source Formulary Brand Name Drug - $106

(4) Non-Formulary Drug - $133, provided the Drug has been prior authorized or does not require prior authorization

c. Any Non-Formulary Drugs on the Pharmacy Benefit Manager's Selective Prior Authorization List are not covered without prior authorization by the Pharmacy Benefit Manager.

d. Prescription drug coverage for Medicare Eligible Individuals will be administered by the Plan's Pharmacy Benefit Manager in accordance with the Center for Medicare & Medicaid Services (CMS) Employer Group Waiver Plan (EGWP) requirements. The prescription drug benefits described in this Article 5 do not apply to Medicare Eligible Individuals.

e. Exception to Brand Name Drug Copayments for New Brand Name Drugs: For any new Brand Name Drug approved by the federal Food and Drug Administration (FDA) after June 1, 2012, including injectable and infusion Drugs, the Copayment is 50% of the cost of the Drug for a minimum of 24 months after the Drug has been approved. Subject to approval by the Board of Trustees, a new Brand Name Drug may be moved to the Copayment levels described in paragraphs (2) through (4) of Subsections a. and b. above prior to the expiration of 24 months. If the Pharmacy Benefit Manager's Pharmacy and Therapeutics committee determines that the new FDA approved Drug is a "must not add" Drug, the Copayment will remain at 50% of the cost of the Drug indefinitely.

f. Prior Approval for Proton Pump Inhibitors (PPIs) and Cholesterol drugs: Brand Name PPIs and Cholesterol drugs are subject to prior approval by the Pharmacy Benefit Manager. If prior approval is not obtained by the prescribing Physician, no benefits are payable by the Plan. If prior approval is received before a prescription is filled for a Brand Name PPI or Cholesterol drug, the Copayment

level for Multi-Source Brand Name Drugs as described in paragraphs (2) of Subsections a. and b. above will apply. Participants are required to utilize the Pharmacy Benefit Manager's defined step therapy before the Plan will pay benefits for Brand Name PPIs and Cholesterol drugs.

g. Immunizations/Vaccines. Immunizations, including travel immunizations, included in the Express Scripts comprehensive vaccine coverage program will be covered at 100%, with no copayment and no deductible, when received from a Participating Pharmacy. A list of immunizations covered under this program is available from Express Scripts. COVID-19 vaccines are also payable at 100% of the Participating Pharmacy Allowed Amount or, for the duration of the Public Health Emergency only, 100% of the average Contract Allowed Amount for services by a Non-Participating Pharmacy.

SECTION 5.02. Covered Expenses. Covered Expenses include the following Drugs and Supplies provided by a Licensed Pharmacist, Physician or Hospital:

a. Drugs prescribed by a Physician licensed by law to administer Drugs.

b. Insulin and Medically Necessary diabetic supplies.

c. Drugs, insulin or Medically Necessary diabetic supplies (1) which are supplied to the Patient in the Physician's office, and (2) for which a charge is made separately from the charge for any other item of expense.

d. Charges made by a Hospital for Drugs, insulin or Medically Necessary diabetic supplies, which are for use outside the Hospital in connection with treatment received in the Hospital, provided that with respect to Drugs, they are prescribed by a Physician licensed by law to administer Drugs.

e. Prenatal vitamins containing fluoride or folic acid.

f. Specialty Drugs as defined by the Pharmacy Benefit Manager, are subject to the following requirements:

(1) In most cases, Specialty Drugs are available only from the Pharmacy Benefit Manager's Mail Order Pharmacy. Specialty Drugs will not be provided by a retail Participating Pharmacy and will not be covered by the Indemnity Medical Plan except for the drugs identified in subsection 3, below, and certain Drugs needed in an emergency situation; these Drugs are the low molecular weight heparin products that are used for blood clots after hip replacement surgeries.

(2) The following Specialty Drugs may be covered under either the medical benefit of the Plan or the prescription drug program. If filled under the prescription drug program, it will be subject to the Retail Pharmacy Copayments specified in SECTION 5.01.a.

Brand	Generic
Zirabev or Mvasi	bevacizumab
Uplizno	ipilimumab
Keytruda	pembrolizumab
Herceptin	trastuzumab
Rituxan	rituximab
Prolia or Xgeva	denosumab
Opdivo	nivolumab
Lupron	leuprorelin

(3) Copayments and Supply Limit. The day supply limit for each prescription order is 30 days. The required Copayments are the Retail Pharmacy Copayments specified in SECTION 5.01.a.

g. Two (2) tobacco cessation attempts per year. Each "tobacco cessation attempt" includes coverage for all FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications with no cost sharing) for a 90-day treatment regimen when prescribed by a Contracted health care provider.

SECTION 5.03. Exclusions. No benefits will be provided for:

a. Drugs taken or administered while the Patient is Hospital confined.

b. Patent or proprietary medicines which do not conform to the definition of "Drugs" set forth in SECTION 1.23. except insulin, insulin injection kits and those items listed as "Covered Expenses" in SECTION 5.02.

c. Appliances, devices, bandages, heat lamps, braces, splints and other supplies or equipment.

d. Vitamins (except prenatal vitamins containing fluoride or folic acid), cosmetics, dietary supplements, health and beauty aids.

e. Charges for prescription drugs containing in excess of a 30-day supply for retail purchase, or in excess of a 90-day supply for drugs purchased through the Fund's mail order Drug program.

f. Infertility drugs.

g. Nose drops or other nasal preparations.

h. Appetite suppressants, or any other weight loss Drug.

i. Drugs prescribed for hair growth or any medications prescribed for cosmetic purposes.

j. Any drugs not Medically Necessary for the care or treatment of an Illness or Injury.

k. Any drugs obtained at a Non-Participating Pharmacy if the Eligible Individual resides within 10 miles of a Participating Pharmacy.

l. Replacement Drugs resulting from loss, theft or breakage.

m. Prescription refills dispensed after 1 year from original date of dispensing.

n. Injectable sexual dysfunction Drugs. Other sexual dysfunction Drugs are limited in the quantity covered.

o. Medications with no federal Food and Drug Administration (FDA) approved indications.

p. Medications used for Experimental indications and/or dosage regimens determined to be Experimental or Investigational; any Investigational or unproven Drugs or therapies.

q. The third purchase of a long-term maintenance Drug from a retail pharmacy. After the second purchase of long-term maintenance Drug at a retail pharmacy, the Drug must be purchased from

the Pharmacy Benefit Manager's mail order pharmacy.

r. Provided that notice is issued by the Plan to an Eligible Individual, a single pharmacy may be designated as the sole provider to dispense one or more prescription drug class(es) to a Participant and/or Dependent. Medications dispensed by pharmacies other than named in such notice are excluded.

s. Compound dermatologist preparations prescribed by a Physician.

t. Not all medications are approved for coverage. Medications excluded under the Pharmacy Benefit Manager's (PBM) Pharmacy and Therapeutics Committee or United Brotherhood of Carpenter's (UBC) Clinical Advisory Committee are not covered. For a list of covered medications, please refer to the directory available on the internet at www.express-scripts.com.

u. Stem cell treatment without federal Food and Drug Administration (FDA) approval.

v. Any medications that do not meet the PBM's clinical guidelines.

w. Any medications that do not satisfy the PBM's prior authorization requirements, step therapies, therapeutic guidelines or other safety and cost saving protocols.

SECTION 5.04. Definitions. For purposes of this Article, the following definitions will apply:

a. Participating Pharmacy. The term "Participating Pharmacy" means a pharmacy which has a contract with the Fund's pharmacy benefit manager to provide prescription drugs to Eligible Individuals.

b. Non-Participating Pharmacy. The "Non-Participating Pharmacy" means a pharmacy which does not have a contract with the Fund's pharmacy benefit manager to provide prescription drugs to Eligible Individuals.

c. "Formulary" means the list of preferred Drugs established by the pharmacy benefit manager contracted by the Fund.

d. "Multi-Source Brand Name Drug" means a brand name Drug that has a generic equivalent.

e. "Single Source Formulary Brand Name Drug" means a brand name Drug that does not have a generic equivalent and is on the Formulary.

ARTICLE 6. MEDICARE SUPPLEMENTAL BENEFITS FOR RETIREES AND DEPENDENTS ELIGIBLE FOR MEDICARE

The Medicare Supplemental Benefits under this Article are payable after the Eligible Individual has satisfied a $128 deductible amount for the calendar year.

SECTION 6.01. Hospital Benefits. If an Eligible Individual who is Eligible for Medicare is confined in a Hospital and benefits are payable by Medicare for the confinement, the Plan will pay an amount equal to the Medicare Part A Deductible for the first 60 days of each Medicare benefit period.

SECTION 6.02. Supplemental Medical Benefits for Other than Outpatient Hospital or Facility Services. If an Eligible Individual receives medical treatment, medical services or supplies of the type for which benefits are provided by Part B of Medicare, the Fund will pay, either:

a. 20% of the covered Medicare maximum allowable charge incurred if the provider does not accept the Medicare assignment of benefits; or

b. 20% of Medicare's allowable charges if the provider does accept the Medicare assignment of benefits.

c. 20% of the Contract Provider negotiated rate, if less than the Medicare allowable charge (California Contract Providers only).

SECTION 6.03. Supplemental Medical Benefits for Outpatient Hospital or Facility Services. If an Eligible Individual receives outpatient medical or surgical treatment in a Hospital or Facility of the type for which benefits are provided by Part B of Medicare, the Fund will pay the remainder of the Medicare allowable charge for the Hospital or Facility charge after Medicare's payment.

SECTION 6.04. Supplemental Medical Benefits for individuals Who Have Entered into a Private Contract with a Provider Not Participating in Medicare. If an Eligible Individual enters into a private contract with a health care provider who is not participating in Medicare and who is therefore prohibited from billing Medicare for services provided to Medicare beneficiaries, the Fund's benefits under SECTION 6.02.a. will be limited to 20% of the amount Medicare would have allowed if the provider was a Medicare participating provider.

SECTION 6.05. Supplemental Medical Benefits for COVID-19 Laboratory Testing. If an Eligible Individual receives laboratory testing for COVID-19 testing of the type for which benefits are provided by Part B of Medicare, the Fund will pay the remainder of the Medicare allowable charge after Medicare's payment, not subject to the Fund's calendar year deductible.

SECTION 6.06. Prescription Drug Benefits for Medicare Eligible Individuals

a. Individual Deductible amount for covered prescriptions is $360 per calendar year.

b. In the Medicare Part D Initial Coverage Stage:

    (1) Generic Drugs:

        (a) $10 copayment per prescription for up to a 31-day supply when filled at a retail

network pharmacy.

(b) $20 copayment per prescription for up to a 90-day supply when filled by mail order pharmacy.

(2) Formulary Brand Drugs:

(a) $40 copayment per prescription for up to a 31-day supply when filled at a retail network pharmacy.

(b) $80 copayment per prescription for up to a 90-day supply when filled by mail order pharmacy.

(3) Non-Formulary Brand Drugs:

(a) $60 copayment per prescription for up to a 31-day supply when filled at a retail network pharmacy.

(b) $120 copayment per prescription for up to a 90-day supply when filled by mail order pharmacy.

(4) Specialty Drugs:

25% patient coinsurance (adjusted annually in accordance with Part D coverage rules)

c. In the Medicare Part D Coverage Gap Stage:

	Patient Coinsurance for Generic Drugs	Patient Coinsurance for Brand Drugs
2016	58%	45%
2017	51%	40%
2018	44%	35%
2019	37%	30%
2020 and after	25%	25%

d. In the Medicare Part D Catastrophic Coverage Stage:

(1) Generic Drugs:

Copayment amount determined by Part D Medicare ($2.95 copayment in 2017) or 5% of the total cost of the drug, not to exceed the Initial Coverage Stage copayment.

(2) Brand Drugs:

Copayment amount determined by Part D Medicare ($7.40 copayment in 2017) or 5% of the total cost of the drug, not to exceed the Initial Coverage Stage copayment.

e. Excluded Drugs:

The Fund will not provide benefits for Medicare Part D excluded drugs or classes of drugs.

ARTICLE 7. EXCLUSIONS, LIMITATIONS AND REDUCTIONS

SECTION 7.01. Excluded Expenses. The Fund will not provide benefits for:

a. Any amounts in excess of Allowed Charges or any services not considered to be customary and reasonable.

b. Services not specifically listed in this Plan as covered services, or those services which are not Medically Necessary.

c. Services for which the Eligible Individual is not legally obligated to pay. Services for which no charge is made to the Eligible Individual. Services for which no charge is made to the Eligible Individual in the absence of insurance or other indemnity coverage, except services received at a non-governmental charitable research Hospital which must meet the following guidelines:

  (1) It must be internationally known as being devoted mainly to medical research;

  (2) At least 10% of its yearly budget must be spent on research not directly related to Patient care;

  (3) At least one-third of its gross income must come from donations or grants other than gifts or payments for Patient care;

  (4) It must accept patients who are unable to pay; and

  (5) Two-thirds of its patients must have conditions directly related to the Hospital's research.

d. Work-related Illness or Injury. The Plan will, however, pay benefits on behalf of an Eligible Individual who has incurred an occupational Injury or Illness on the following conditions:

  (1) The Eligible Individual signs an agreement to diligently prosecute his/her claim for workers' compensation benefits or for any other available occupational compensation benefits;

  (2) The Eligible Individual agrees to reimburse the Fund for benefits paid on his/her behalf by consenting to a lien against any occupational compensation benefits received through adjudication, settlement or otherwise; and

  (3) The Eligible Individual cooperates with the Fund or its designated representative by taking reasonably necessary steps to secure reimbursement, through legal action or otherwise, for any benefits paid for the Eligible Individual's occupational Injury or Illness.

e. Conditions caused by or arising out of an act of war or armed invasion.

f. Services rendered while an Eligible Individual is confined in a Hospital operated by the United States Government or an agency of the United States Government except that the Plan, to the extent required by law, will reimburse a Veterans Administration (VA) Hospital for care of a non-service related disability if the Plan would normally cover the care if the VA were not involved.

g. Routine nursery care of a newborn Dependent child furnished in a Non-Contract Facility.

h. Services furnished by a naturopath or any other provider not meeting the definition of Physician.

i. Professional services received from a registered nurse or physical therapist who lives in the Eligible Individual's home or who is related to the Eligible Individual by blood or marriage.

j. Custodial Care or rest cures. Services provided by a rest home, a home for the aged, a nursing home or any similar facility, except the Plan may cover a stay at a long-term acute care facility when a patient is receiving rehabilitation therapy immediately after or instead of an acute inpatient hospitalization. For the Plan to consider such services, the stay must receive prior authorization and the patient must continue to make treatment progress as documented by patient notes.

k. Educational services, supplies or equipment, including, but not limited to computers, computer devices/software, printers, books, tutoring or interpreters, visual aids, vision therapy, auditory or speech aids/synthesizers, auxiliary aids such as communication boards, listening systems, device/programs/ or developmental delays or auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, reading or self-esteem, etc., special education and associated costs in conjunction with sign language education for a patient or family members, and implantable medical identification/tracking devices.

l. Dental plates, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth or treatment to the teeth or gums other than for tumors, except as specifically provided under SECTION 3.07.h.

m. Services of an Optometrist except as specifically provided in SECTOIN 3.06.h., vision therapy including orthoptics, routine eye exams and routine eye refractions. Eyeglasses and contact lenses. Any surgery for correction of myopia or any other refractive eye surgery.

n. Cosmetic surgery or other services for beautification, except to correct functional disorders or for conditions resulting from an Injury or reconstructive surgery following a mastectomy.

o. Orthopedic shoes (except when joined to braces) or shoe inserts (except for custom-made orthotics), air purifiers, air conditioners, humidifiers, exercise equipment and supplies for comfort, hygiene or beautification.

p. Services for which benefits are payable under any other programs provided by the Fund.

q. In addition to any other limitations generally applicable to this Plan or its coordination of benefit provisions, where this Plan, as secondary is coordinating benefits with another plan which has entered into a preferred provider agreement with a medical or hospital provider, this Plan will pay no more than the difference between:

    (1) The lesser of:

        (a) The normal charges billed for the expenses by the provider, or

        (b) The contractual rate for that expense under a preferred provider agreement between the provider and the plan that this Plan is coordinating with, and

    (2) The amount that the other plan pays as primary.

r. Nutritional counseling or food supplements or substitutes. This exclusion does not apply to nutritional counseling specifically provided in SECTION 3.07.m., or nutritional counseling services that are medically necessary for the treatment of an individual diagnosed with a mental health condition, such as an eating disorder. In addition, this exclusion does not apply to Total

Parenteral Nutrition (TPN) that is approved by Anthem as Medically Necessary and curative in nature.

s. Speech therapy or occupational therapy (except rehabilitation treatment following an Illness or Injury or as part of an approved autism therapy plan).

t. Expenses for the treatment of infertility along with services to induce pregnancy and complications resulting from those services, including, but not limited to: services, prescription drugs, procedures or devices to achieve fertility, in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor egg/semen or other fees, cryostorage of egg/sperm, adoption, ovarian transplant, infertility donor expenses, fetal implants, fetal reduction services, surgical impregnation procedures and reversal of sterilization.

u. Hypnotism, biofeedback, stress management and any goal oriented behavior modification therapy, such as to quit smoking, lose weight or control pain.

v. Non-surgical services which are primarily for weight loss.

w. Any services and supplies in connection with Experimental or Investigational Procedures. For purposes of this Exclusion, the term Experimental or Investigational Procedures means a drug or device, medical treatment or procedure if:

(1) the drug or device cannot be lawfully marketed without approval of the United States Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;

(2) the drug, device, medical treatment or procedure, or the Patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval;

(3) Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials, is the research, experimental, study or investigational arm of ongoing phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

For purposes of this Exclusion, "Reliable Evidence" will mean only published reports and articles in peer reviewed authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of 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.

x. Claims submitted more than 12 months from the date of service.

y. Illness, Injury, disease or other condition for which a third party (or parties) is or may be liable or legally responsible by reason of an act, omission or insurance coverage of that third party or parties unless an Eligible Individual complies with SECTION 7.02.

z. Services that are habilitative in nature (except as part of an approved autism therapy plan).

aa. Expenses from a Non-Contract Hospital, Non-Contract Facility or other Non-Contract provider who did not complete enrollment in the Medicare program, except as otherwise provided by SECTION 1.02.c.

bb. Providers, following an investigation and recommendation by the Plan's Fraud, Waste and Abuse vendor, who have been determined to have engaged in fraudulent activity.

SECTION 7.02. Third Party Liability.

a. If an Eligible Individual has an Illness, Injury, disease or other condition for which a third party (or parties) is or may be liable or legally responsible by reason of an act, omission or insurance coverage of that third party or parties (hereinafter referred to collectively as "responsible third party"), the Fund shall not be liable to pay any benefits. However, upon the execution and delivery to the Fund of all documents it requires to secure the Plan's right of reimbursement, including without limitation a Reimbursement Agreement, the Fund may pay benefits on account of Hospital, medical or other expenses in connection with, or arising out of, such Illness, Injury, disease or other condition. The Fund shall have all rights as set forth herein.

b. The Fund shall be reimbursed first, before any other claims, for 100% of benefits paid by the Fund from any recovery received by way of judgment, arbitration award, verdict, settlement or other source by the Eligible Individual or by any other person or party for the Eligible Individual, pursuant to such Illness, Injury, disease or other condition, including recovery from any under-insured or uninsured motorist coverage or other insurance, even if the judgment, verdict, award, settlement or any recovery does not make the Eligible Individual whole or does not specifically include medical expenses. The Fund shall be reimbursed from said recovery without any deduction for legal fees incurred or paid by the Eligible Individual. The Eligible Individual and/or his or her attorney must promise not to waive or impair any of the rights of the Fund without written consent. In addition, the Fund shall be reimbursed for any legal fees incurred or paid by the Fund to secure reimbursement of said benefit paid by the Fund.

c. If the Fund pays any benefits because of such Illness, Injury, disease or other condition, the Fund shall also have an automatic lien and/or constructive trust on that portion of any recovery obtained by the Eligible Individual or by any other person or party for the Eligible Individual, for such Illness, Injury, disease or other condition which is due for said benefits paid by the Fund, even if the judgment, verdict, award, settlement or any recovery does not make the Eligible Individual whole or does not specifically include medical expenses. Such lien may be filed with the Eligible Individual, his or her agent, insurance company, any other person or party holding said recovery for the Eligible Individual, or the court; and such lien shall be satisfied from any recovery received by the Eligible Individual, however classified, allocated or held.

d. If reimbursement is not made as specified, the Fund, at its sole option, may take any legal and/or equitable action to recover the amount that was paid for the Eligible Individual's Illness, Injury, disease or other condition (including any legal expenses incurred or paid by the Fund) and/or may offset future benefits payments by the amount of such reimbursement (including any legal fees incurred or paid by the Fund). The Fund, at its sole option, may cease paying benefits, if there is a reasonable basis to determine that the Eligible Individual will not honor the terms of the Plan, or there is a reasonable basis to determine that this Section is not enforceable.

e. By accepting benefits from the Fund, the Eligible Individual further agrees:

(1) To prosecute any claim for damages diligently;

(2) To promptly advise the Fund whenever a claim is made against the responsible third party with respect to any loss for which Fund benefits have been or will be paid because of an Illness, Injury, disease or other condition caused by the responsible third party;

(3) The Fund's reimbursement rights shall be considered as a first priority claim against another person or entity, to be reimbursed before any other claims, including claims for general damages;

(4) To cooperate and assist the Fund in obtaining reimbursement for payments made, and to refrain from any act or omission that might hinder any reimbursement;

(5) To provide the Fund with all relevant information or documents requested;

(6) To consent to the lien and/or constructive trust that shall exist in favor of the Fund upon all funds recovered by the Eligible Individual against the responsible third party;

(7) To hold proceeds of any settlement, verdict, judgment or other recovery in trust for the benefit of the Fund, and that the Fund shall be entitled to recover reasonable attorney's fees incurred in collecting reimbursement of benefits due;

(8) To execute any documents necessary to secure reimbursement;

(9) Not to assign any rights or cause of action that the Eligible Individual may have against the responsible third party to recover medical expenses without the express written consent of the Fund;

(10) The Fund has the right to intervene, independently of the Eligible Individual, in any legal action brought against the third party or any insurance company, including the Eligible Individual's own carrier for uninsured motorists' coverage;

(11) The Fund's right of first reimbursement will not be affected, reduced or eliminated by the make whole doctrine, comparative fault or regulatory diligence or the common fund doctrine;

(12) It will constitute an immediate breach of the agreement and a failure to comply with the terms of the Plan, if, within 30 days following recovery from the responsible third party or insurer, the Eligible Individual does not agree to reimburse the Fund pursuant to this SECTION 7.02., and pay the reimbursement amount. If the Eligible Individual breaches the agreement and/or fails to comply with this SECTION 7.02., the amount of benefits paid by the Fund which are related to the Injury, Illness, disease or other condition will become immediately due and payable together with interest, and all costs of collection, including reasonable attorney fees and court costs.

f. If the Eligible Individual does not receive any payment from a third party to reimburse for the Illness, Injury, disease or other condition caused by the responsible third party, the Eligible Individual does not have to reimburse the Fund for any benefits properly paid to the Eligible Individual. If the Eligible Individual receives payment from the responsible third party, the Eligible Individual does not have to pay the Fund more than the amount the responsible third party paid to the Eligible Individual.

SECTION 7.03. Coordination of Benefits. If an Eligible Individual is entitled to benefits from another Group Plan for Hospital or medical expenses for which benefits are also due from this Plan, then the benefits provided by the Plan will be paid in accordance with the following provisions, not to exceed the

dollar amount of benefits which would have been paid in the absence of other group coverage or 100% of the expenses actually incurred by the Eligible Individual.

a. The benefits of the plan that covers the person as a participant, employee or subscriber are always determined before the benefits of a plan covering the person as a dependent (except when Medicare Secondary Payer provisions apply). This provision applies to any Dependent child who is covered under another plan as a participant, employee or subscriber and supersedes any other provisions of this SECTION 7.03 regarding Dependent children.

b. If the Eligible Individual is the Dependent Spouse of a Retiree, Fund benefits will be paid for eligible expenses not covered by the other Group Plan.

c. If the Eligible Individual for whom claim is made is a Dependent child whose parents are not separated or divorced, or whose parents are divorced and have joint custody, the benefits of the Group Plan which covers the Eligible Individual as a Dependent child of a parent whose date of birth, excluding year of birth, occurs earlier in the calendar year, will be determined before the benefits of the Group Plan which covers the Eligible Individual as a Dependent child of a parent whose date of birth, excluding year of birth, occurs later in the calendar year. If either Group Plan does not have the provisions of this rule c. regarding Dependents, which results either in each Group Plan determining its benefits before the other or in each Group Plan determining its benefits after the other, the provisions of this rule will not apply, and the rule set forth in the Plan which does not have the provisions of this rule c. will determine the order of benefits.

d. In the case of an Eligible Individual for whom claim is made as a Dependent child whose parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a Plan which covers the child as a dependent of the parent without custody.

e. In the case of an Eligible Individual for whom claim is made as a Dependent child whose parents are divorced and the parent with custody of the child remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a Plan which covers that child as a dependent of the stepparent, and the benefits of a Plan which covers that child as a dependent of the stepparent will be determined before the benefits of a Plan which covers that child as a dependent of the parent without custody.

f. In the case of an Eligible Individual for whom claim is made as a Dependent child whose parents are separated or divorced, where there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, then, notwithstanding rules d. and e. above, the benefits of a Plan which covers the child as a dependent of the parent with the financial responsibility will be determined before the benefits of any other Plan which covers the child as a dependent child.

g. When rules a., b., c., d., e., or f. do not establish an order of benefit determination, Fund benefits will be provided without reduction if the Eligible Individual has been eligible continuously for benefits from this Fund for a longer period of time than he or she has been continuously eligible for benefits from the other Group Plan, provided that:

   (1) the benefits of a Group Plan covering the Eligible Individual on whose expenses claim is based as a laid-off or retired employee, or Dependent of that person, will be determined after the benefits of any other Group Plan covering the person as an active employee, other than a laid-off or retired employee, or Dependent of the active employee; and

(2) if either Group Plan does not have a provision regarding laid-off or retired employees, which results in each Group Plan determining its benefits after the other, then the provision (1) above will not apply.

h. **Coordination with Prepaid Plans**. Regardless of whether this Plan may be considered primary or secondary under its coordination of benefits provisions, in the event an Eligible Individual (i) has coverage under the indemnity portion of this Plan, and (ii) has coverage under a prepaid program under another Group Plan (regardless of whether the Eligible Individual must pay a portion of the premium for that plan), and (iii) uses the prepaid program for services also covered by this Plan, then this Plan will only reimburse the copayments required of the Eligible Individual under the pre-paid plan, and only if the co-payments are required of every person covered by that program. Except for the copayments specified above, the Plan will not pay expenses of eligible employees or dependents covered by prepaid programs of other plans. For purposes of this Plan, the term "prepaid program" will include health maintenance organizations, individual practice associations, and any other programs that the Board in its sole discretion deems to be essentially similar to these prepaid arrangements.

i. **Coordination with Preferred Provider Plans.** Where this Plan, as secondary, is coordinating benefits with another plan which has entered into a preferred provider agreement with a medical or Hospital provider, this Plan will pay no more than the difference between:

(1) The lesser of:

(a) The normal charges billed for the expenses by the provider, or

(b) The contractual rate for the expense under a preferred provider agreement between the provider and the plan that this Plan is coordinating with, and

(2) The amount that the other plan pays as primary.

SECTION 7.04. Coordination with Medicaid. Payments by this Plan for benefits with respect to an Eligible Individual will be made in compliance with any assignment of rights made by or on behalf of the Eligible Individual as required by California's plan for medical assistance approved under Title XIX, Section 1912(a)(1)(A) of the Social Security Act (Medicaid).

SECTION 7.05.

Where payment has been made by the State under Medicaid for medical assistance in any case where this Plan has a legal liability to make payment for that assistance, payment for the benefits will be made in accordance with any State law which provides that the State has acquired the rights with respect to an Eligible Individual to the payment for that assistance. In no event will payment be made by this Plan, under this provision, for claims submitted more than one year from the date expenses were incurred. Reimbursement to the State, like any other entity which has made payment for medical assistance where this Plan has a legal liability to make payment, will be equal to Plan benefits or the amount actually paid, whichever is less.

ARTICLE 8. GENERAL PROVISIONS

SECTION 8.01.

a. All benefits will be paid by the Fund to the Retiree as they accrue upon receipt of written proof, satisfactory to the Fund, covering the occurrence, character and extent of the event for which the claim is paid. The Board of Trustees has the exclusive right and discretion to construe and interpret the Plan and is the sole judge of the standard of proof required in any claim and in the application and interpretation of the Plan. Any dispute as to the eligibility, type, amount or duration of benefits or any right or claim to payments from the Fund will be resolved by the Board or its duly authorized designee under and pursuant to the provisions of the Plan and the Trust Agreement and, its decision is final and binding upon all parties subject only to judicial review as may be in harmony with federal labor law.

b. Proof of claim forms, as well as other forms, and method of administration and procedure will be solely determined by the Fund.

SECTION 8.02.

a. Except to the extent otherwise specifically provided in Subsections b. and c. of this Section or elsewhere in the Plan, each Retiree, Dependent or other beneficiary is restrained from selling, transferring, anticipating or otherwise disposing of any benefit payable under the Plan, or any other right or interest under the Plan, and the Fund will not be required to recognize the sale, transfer, anticipation, assignment, alienation, hypothecation or other disposition. Any such benefit, right or interest will not be subject in any manner to voluntary transfer or transfer by operation of law or otherwise, and will be exempt from the claims of creditors or other claimants and from all orders, decrees, garnishments, executions or other legal process or proceedings to the fullest extent permitted by federal law.

b. Any Retiree may direct that benefits due to them be paid to an institution in which the Retiree or his/her Dependent is hospitalized, or to any provider of medical, drug, dental or other health services or supplies in consideration for Hospital, medical or other services rendered, or supplies furnished, or to any other agency that may have provided or paid for, or agreed to provide or pay for, any benefits provided.

c. In the event that through mistake or any other circumstance, a Retiree, Dependent or other beneficiary has been paid or credited with more than he or she is entitled to under the Plan or under the law or has become obligated to the Fund under an indemnity agreement or a third party liability agreement or in any other way, the Fund may set off, recoup and recover the amount of the overpayment, excess credit or obligation from benefits accrued or thereafter accruing to the Retiree, Dependent or beneficiary, and not yet distributed, in any installments and to the extent determined by the Board.

SECTION 8.03. Benefits will be paid by the Fund only if notice of claim is made within ninety days from the date on which Covered Expenses were first incurred unless it will be shown by the Retiree not to have been reasonably possible to give notice within this time limit, but in no event will benefits be allowed if notice of claim is made beyond one year from the date on which expenses were incurred.

SECTION 8.04. In the event the Fund determines that the Retiree is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Retiree has not provided the Fund with an address at which he/she can be located for payment, the Fund may during the lifetime of the Retiree, pay any amount otherwise payable to the Retiree to the husband or wife or relative by blood of the Retiree, or to any other person or institution determined by the Fund to be equitably entitled to payment.

In the case of the death of the Retiree before all amounts payable under the Plan have been paid, the Fund may pay this amount to any person or institution determined by the Fund to be equitably entitled to payment. The remainder of any amount owing will be paid to one or more of the following surviving relatives of the Retiree: Spouse, child or children, mother, father, brothers or sisters, or to the Retiree's estate, as the Board in its sole discretion may designate. Any payment in accordance with this provision will discharge the obligation of the Fund.

SECTION 8.05. Claims and Appeals Procedures.

a. **Definitions.**

(1) Adverse Benefit Determination. An "Adverse Benefit Determination" is any denial, reduction, termination of or failure to provide or make payment for a benefit (either in whole or in part) under the Plan. Each of the following is an example of an Adverse Benefit Determination:

(a) a payment of less than 100% of a Claim for benefits (including coinsurance or copayment amounts of less than 100% and amounts applied to the deductible);

(b) a denial, reduction, termination of or failure to provide or make payment for a benefit (in whole or in part) resulting from any utilization review decision;

(c) a failure to cover an item or service because the Fund considers it to be experimental, investigational, not Medically Necessary or not medically appropriate;

(d) a decision that denies a benefit based on a determination that a claimant is not eligible to participate in the Plan.

Presentation of a prescription order at a pharmacy, where the pharmacy refuses to fill the prescription unless the claimant pays the entire cost, is not considered an Adverse Benefit Determination (but only to the extent that the pharmacy's decision for denying the prescription is based on coverage rules predetermined by the Fund).

(2) Claim. The term "Claim" means a request for a benefit made by an individual in accordance with the Fund's reasonable procedures.

Casual inquiries about benefits or the circumstances under which benefits might be paid are not considered Claims. Nor is a request for a determination of whether an individual is eligible for benefits under the Plan considered to be a Claim. However, if a claimant files a Claim for specific benefits and the Claim is denied because the individual is not eligible under the terms of the Plan, that coverage determination is considered a Claim.

The presentation of a prescription order at a pharmacy does not constitute a Claim, to the extent benefits are determined based on cost and coverage rules predetermined by the Fund. If a Physician, Hospital or pharmacy declines to render services or refuses to fill a prescription unless the individual pays the entire cost, the individual should submit a Post-Service Claim for the services or prescription, as described under Claim Procedures, below.

A request for Precertification or Prior Authorization of a benefit that does not require Precertification or Prior Authorization by the Fund as a condition for receiving maximum benefits is not considered a Claim. However, requests for Precertification or Prior Authorization of a benefit where the Fund does require Precertification or Prior Authorization are considered Claims and should be submitted as Pre-Service Claims (or Urgent Claims, if applicable), as described under Claim Procedures, below.

(a) Claims are Categorized as Follows:

(i) Urgent Claim. The term "Urgent Claim" means a Claim for medical care or treatment that, if normal Pre-Service standards for rendering a decision were applied, would seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

(ii) Pre-Service Claim. The term "Pre-Service Claim" means a Claim for a *benefit for which the Fund requires Precertification or Prior Authorization before medical care is obtained in order to receive the maximum benefits allowed under the Plan.

(iii) Concurrent Claim. The term "Concurrent Claim" means a Claim that is reconsidered after an initial approval has been made that results in a reduction, termination or extension of the previously approved benefit.

(iv) Post-Service Claim. The term "Post-Service Claim" means a Claim for benefits that is not a Pre-Service, Urgent or Concurrent Claim. This will generally be a claim for reimbursement for services already rendered.

(v) Disability Claim. The term "Disability Claim" means any Claim that requires a finding of Total Disability as a condition of eligibility.

(3) Relevant Documents. "Relevant Documents" include documents pertaining to a Claim if they were relied upon in making the benefit determination, were submitted, considered or generated in the course of making the benefit determination, demonstrate compliance with the administrative processes and safeguards required by the regulations, or constitute the Fund's policy or guidance with respect to the denied treatment option or benefit. Relevant Documents could include specific Fund rules, protocols, criteria, rate tables, fee schedules or checklists and administrative procedures that prove that the Fund's rules were appropriately applied to a Claim.

b. **Claim Procedures.**

(1) **Timing Requirement for payment of Emergency Services, Non-Emergency Services at PPO Facilities by Non-PPO Providers, and Air Ambulance**

The Plan will make an initial payment or notice of denial of payment for Emergency Services, Non-Emergency Services at Services at Contract Facilities by Non-Contract Providers, and Air Ambulance Services within 30 calendar days of receiving a clean claim from the Non-Contract Provider. The 30-day calendar period begins on the date the plan receives the information necessary to decide a claim for payment for the

services.

If a claim is subject to the No Surprises Act, the Participant cannot be required to pay more than the Cost-sharing under the Plan, and the provider or facility is prohibited from billing the Participant or Dependent in excess of the required Cost sharing.

If a Non-Contract Provider or facility and the Plan enter into the Independent Dispute Resolution (IDR) process under the federal No Surprises Act (Public Law 116-260, Division BB) and do not agree before the date on which a certified IDR entity makes a determination with respect to such item or service, the allowable amount is the amount of such determination. The Participant or Dependent has no right nor obligation to participate in any IDR process under the federal No Surprises Act.

(2) Urgent Claims. The Fund will determine whether a Claim is an Urgent Claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, if a Physician with knowledge of the patient's medical condition determines that the Claim is an Urgent Claim, and notifies the Fund of such, it will be treated as an Urgent Claim.

Urgent Claims, which may include requests for Precertification of Hospital admissions and Prior Authorization of services, must be submitted by telephone or in person. Urgent Care Claims may not be submitted via the US Postal Service.

For properly filed Urgent Claims, the Fund or its designated Review Organization will respond to the claimant and provider with a determination by telephone as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claim. The determination will also be confirmed in writing.

If an Urgent Claim is received without sufficient information to determine whether, or to what extent, benefits are covered or payable, the Fund or its designated Review Organization will notify the claimant as soon as possible, but not later than 24 hours after receipt of the Claim, of the specific information necessary to complete the Claim. The claimant must provide the specified information within 2 business days after receiving the request for additional information. If the information is not provided within that time, the Claim will be denied.

During the period in which the claimant is allowed to supply additional information, the normal deadline for making a decision on the Claim will be suspended. The deadline is suspended from the date of the extension notice until either 2 business days or the date the claimant responds to the request, whichever is earlier. Notice of the decision will be provided no later than 48 hours after receipt of the specified information.

If a claimant improperly files an Urgent Claim, the Trust Fund Office or its designated Review Organization will notify the claimant as soon as possible but not later than 24 hours after receipt of the Claim of the proper procedures required to file an Urgent Claim. Improperly filed claims include, but are not limited to: (i) claims that are not directed to a person or organizational unit customarily responsible for handling benefit matters; or (ii) claims that do not name a specific claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested. The notification may be oral unless the claimant or authorized representative requests written notification. Unless refiled properly, it will not constitute a Claim.

(3) Pre-Service Claims. Under the terms of this Plan, claimants are required to obtain Precertification by the Professional Review Organization (PRO) for admission to a Hospital or inpatient treatment facility on a non-emergency basis or for certain outpatient surgical procedures as outlined in SECTION 3.04.(b) in order to receive maximum benefits.

The Fund's designated PRO will notify the claimant of an improperly filed **Pre-Service Claim** as soon as possible, but no later than 5 days after receipt of the claim, of the proper procedures to be followed in filing a claim. The claimant will only receive notice of an improperly filed Pre-Service Claim if the claim is submitted to the appropriate office and includes: (i) claimant's name, (ii) claimant's specific medical condition or symptom, and (iii) a specific treatment, service or product for which approval is requested. Unless the claim is re-filed properly, it will not constitute a claim.

For properly filed Pre-Service Claims, the claimant (and the claimant's doctor) will be notified of a decision within *15 days* after receipt of the claim unless additional time is needed. The time for response may be extended for up to an additional *15 days* if necessary due to matters beyond the control of the PRO. If an extension is necessary, the claimant will be notified prior to the expiration of the initial 15-day period of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If an extension is required because the Fund needs additional information from the claimant, the Fund will issue a request for additional information that specifies the information needed. The claimant will have 45 days from the date of the notification to supply the additional information. If the information is not provided within that time, the Claim will be denied. During the 45-day period in which the claimant is allowed to supply additional information, the normal deadline for making a decision on the Claim will be suspended. The deadline is suspended from the date of the Request for Additional Information until the earlier of: (i) 45 days; or (ii) the date the claimant responds to the request. The PRO then has 15 days to make a determination on the claim.

(4) Concurrent Claims. Any request by a claimant to extend an approved Urgent Claim will be acted upon by the PRO within 24 hours of receipt of the Claim, provided the Claim is received at least 24 hours prior to the expiration of the approved Urgent Claim. A request to continue a plan of treatment that is in progress that does not involve an Urgent Claim will be decided in enough time to request an appeal and to have the appeal decided before the benefit is reduced or terminated.

(5) Post-Service Claims. The claim form must be completed in full and an itemized bill(s) must be attached to the claim form in order for the request for benefits to be considered a Claim. Claimants do not have to submit an additional claim form if the bill(s) are for a continuing illness and claimant filed a signed claim form within the past calendar year period. The provider or Physician may file the claim on the claimant's behalf. The claim form and/or itemized bill(s) must include the following information for the request to be considered a Claim and for the Fund to be able to decide the claim:

Claimant completes:

(a) Participant or Retiree name

(b) Patient Name

(c) Patient's Date of Birth

(d) SSN or Participant ID number of Retiree

(e) Date of Service

(f) Information on other insurance coverage, if any, including coverage that may be available to Retiree's Spouse through his or her employer

(g) If treatment is due to an accident, accident details

Provider completes:

(a) CPT-4 (the code for physician services and other health care services found in the *Current Procedural Terminology, Fourth Edition*, as maintained and distributed by the American Medical Association) or HCPCS code

(b) ICD-10 (the diagnosis code found in the *International Classification of Diseases, 10th Edition, Clinical Modification* as maintained and distributed by the U.S. Department of Health and Human Services)

(c) Billed charge (bills must be itemized with all dates of Physician visits shown)

(d) Federal taxpayer identification number (TIN) of the provider

(e) Provider's billing name, address and phone number

A Post-Service Claim is considered to have been filed upon receipt of the Claim by the Trust Fund Office.

Ordinarily, claimants will be notified of decisions on Post-Service Claims within 30 days from the receipt of the Claim by the Trust Fund Office. The Fund may extend this period one time for up to 15 days if the extension is necessary due to matters beyond the control of the Fund. If an extension is necessary, the claimant will be notified, before the end of the initial 30-day period, of the circumstances requiring the extension and the date by which the Fund expects to render a decision.

If an extension is required because the Fund needs additional information from the claimant, the Fund will request additional information from provider and/or claimant via fax, telephone, Explanation of Benefits (EOB) or letter. The request will specify the information needed. The claimant will then have 45 days from receipt of the request to supply the additional information. If the information is not provided within that time, the Claim will be denied. The deadline for making a decision on the Claim will be suspended from the date of the request for additional information until the earlier of: (i) 45 days after the request is sent; or (ii) the date the claimant responds to the request. The Fund then has 15 days to make a decision and notify the claimant of its determination.

If the Fund determines that additional information is required from the claimant, and the claimant fails to provide any requested information within 45 days, the Fund will issue a notice of adverse benefit determination.

(6) <u>Authorized Representatives</u>. An authorized representative, such as a Spouse or an adult child, may submit a Claim or appeal on behalf of a claimant if the claimant has previously designated the individual to act on his or her behalf through a form available at the Fund Office. The Trust Fund Office may request additional information to verify that the designated person is authorized to act on the claimant's behalf. Even if the claimant has designated an authorized representative, the claimant must personally sign a claim form and

file it with the Fund Office at least annually.
A health care professional with knowledge of the claimant's medical condition may act as an authorized representative in connection with an Urgent Claim without the claimant having to designate an authorized representative.

(7) Notice of Initial Benefit Determination. The claimant will be provided with written notice of the initial benefit determination. If the determination is an Adverse Benefit Determination, the notice will include:

(a) the specific reason(s) for the determination;

(b) reference to the specific Plan provision(s) on which the determination is based;

(c) a description of any additional material or information necessary to perfect the Claim, and an explanation of why the material or information is necessary;

(d) a description of the appeal procedures and applicable time limits;

(e) a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following the appeal of an Adverse Benefit Determination;

(f) if an internal rule, guideline or protocol was relied upon in deciding the Claim, a statement that a copy is available upon request at no charge;

(g) if the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge;

(h) for Urgent Claims, a description of the expedited review process applicable to Urgent Claims (for Urgent Claims, the notice may be provided orally and followed with written notification).

c. **Appeal Procedures.**

(1) Appealing an Adverse Benefit Determination. If any Claim is denied in whole or in part, or if the claimant disagrees with the decision made on a Claim, the claimant may appeal the decision in the manner specified below. Appeals must be submitted to the Trust Fund Office within 180 days after the claimant receives the notice of Adverse Benefit Determination, must be accompanied by any pertinent material not already furnished to the Fund, and must state why the claimant believes the Claim should not have been denied.

(a) Urgent Claims. Appeals of Adverse Benefit Determinations regarding Urgent Claims must be made either by calling the designated Review Organization or by other available similarly expeditious method.
Appeals of Urgent Claims may **not** be submitted via the US Postal Service.

(b) Concurrent Claims. Appeals of Adverse Benefit Determinations regarding Concurrent Claims must be made in the same manner described for Urgent Claims.

(c) Pre-Service Claims. Appeals of Adverse Benefit Determinations regarding Pre-Service Claims must be in writing via mail or facsimile. A Pre-Service Claim appeal that is received with additional information which, upon review, allows additional benefits to be approved by the Trust Fund Office or its designated Review Organization in accordance with Fund provisions will not be considered an appeal, but a new Pre-Service Claim.

(d) Post-Service Claims. The appeal of a Post-Service Claim must be submitted in writing to the Trust Fund Office within 180 days after receipt of the Notice of Adverse Benefit Determination and must include:

(i) the Patient's name and address;

(ii) the Retiree's name and address, if different;

(iii) a statement that this is an appeal of an Adverse Benefit Determination to the Board of Trustees;

(iv) the date of the Adverse Benefit Determination; and

(v) the basis of the appeal, i.e., the reason(s) why the Claim should not be denied.

(2) The Appeal Process. The claimant will be given the opportunity to submit written comments, documents, and other information for consideration during the appeal, even if such information was not submitted or considered as part of the initial benefit determination. The claimant will be provided, upon request and free of charge, reasonable access to and copies of all Relevant Documents pertaining to his or her Claim.

A different person will review the appeal than the person who originally made the initial Adverse Benefit Determination on the Claim. The reviewer will not give deference to the initial Adverse Benefit Determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by the claimant.

If the Claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. Upon request, the claimant will be provided with the identification of medical or vocational experts, if any, that gave advice on the Claim, without regard to whether the advice was relied upon in deciding the Claim.

(3) Timeframes for Sending Notices of Appeal Determinations.

(a) Urgent Claims. Notice of the appeal determination for Urgent Claims will be sent within 72 hours of receipt of the appeal by the Trust Fund Office or its designated Review Organization.

(b) Pre-Service Claims. Notice of the appeal determination for Pre-Service claims will be sent within 30 days of receipt of the appeal by the Trust Fund Office or its designated Review Organization.

(c) Concurrent Claims. Notice of the appeal determination for a Concurrent Claim will be sent by the Trust Fund Office or its designated Review Organization prior to the termination of the benefit.

(d) Post-Service Claims. Ordinarily, decisions on appeals involving Post-Service will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of claimant's request for review. However, if the request for review is received at the Trust Fund Office less than 30 days before the next regularly scheduled meeting, the request for review may be considered at the second regularly scheduled meeting following receipt of the claimant's request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of the claimant's request for review may be necessary. The claimant will be advised in writing in advance of this

extension. Once a decision on review of claimant's Claim has been reached, the claimant will be notified as soon as possible, but no later than 5 days after the date of the decision.

(e) If the decision on review is not furnished to the claimant within the time specified in this Subsection c.(3), claimant's Claim will be deemed denied upon review. Claimant will be free to bring an action upon his or her Claim in accordance with Subsection c.(5), below.

(4) Content of Appeal Determination Notices. The determination of an appeal will be provided to the claimant in writing. The notice of a denial of an appeal will include:

(a) the specific reason(s) for the determination;

(b) reference to the specific Plan provision(s) on which the determination is based;

(c) a statement that the claimant is entitled to receive reasonable access to and copies of all documents relevant to the Claim, upon request and free of charge;

(d) a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal;

(e) if an internal rule, guideline or protocol was relied upon, a statement that a copy is available upon request at no charge; and

(f) if the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge.

(5) **External Review of certain claims for Emergency Services, Non-Emergency services from Non-PPO provider at PPO facility, and air ambulance services.** This voluntary External Review process is intended to comply with the No Surprises Act external review requirements. For purposes of this section, references to "claimant" include the Employee, covered Dependent(s) and any authorized representatives; and references to "Plan" include the Plan and its designee(s).

External Review is only applicable in certain cases. The claimant may seek further external review, by an Independent Review Organization ("IRO"), only in the situation where the appeal of a health care claim, whether urgent, concurrent, pre-service or post-service claim is denied and is a claim for emergency services, non-emergency services from a Non-PPO provider at a PPO facility, or air ambulance.

External Review is not available for any other types of denials, including if a claim was denied due to the claimant's failure to meet the requirements for eligibility under the terms of the Plan.

There is no cost to the claimant to request an external review. The Plan assumes responsibility for fees associated with External Reviews outlined in this document.

Generally, the claimant may only request External Review after he or she has exhausted the Plan's internal claims and appeals process described above. This means that, generally, a claimant may only seek External Review after a final determination has been made on an appeal.

There are two types of External Claims outlined below: Standard (Non-Urgent) Claims and Expedited Urgent Care Claims.

(a) **External Review of Standard (Non-Urgent) Claims.** A claimant may request for External Review of a standard (not urgent) claim must be made, in writing, within four (4) months of the date that a notice of a Claim Appeal Benefit Determination is received. For convenience, these Determinations are referred to below as an "Adverse Determination," unless it is necessary to address them separately.

1. ***Preliminary Review of Standard Claims.*** **Within five (5) business days** of the Plan's receipt of a claimant's request for External Review of a standard claim, the Plan will complete a preliminary review of the request to determine whether:

   i) The claimant was covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

   ii) The Adverse Determination satisfies the above-stated requirements for External Review and does not, for example, relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan.

   iii) The claimant has exhausted the Plan's internal claims and appeals process (except, in limited, exceptional circumstances when under the regulations the claimant is not required to do so); and

   iv) The claimant has provided all of the information and forms required to process an external review.

2. **Within one (1) business day** of completing its preliminary review, the Plan will notify the claimant in writing as to whether the request for External Review meets the above requirements for External Review. This notification will inform the claimant:

   i) If the request is complete and eligible for External Review; or

   ii) If the request is complete but not eligible for External Review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

   iii) If the request is not complete (incomplete), the notice will describe the information or materials needed to complete the request, and allow the claimant to perfect (complete) the request for External Review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

3. ***Review of Standard Claims by an Independent Review Organization (IRO).*** If the request is complete and eligible for External Review, the Plan will assign the request to an IRO. (Note that the IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan may rotate assignment among IROs with which it contracts.) Once the claim is assigned to an IRO, the following procedure will apply:

i) The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review, including directions about how the claimant may submit additional information regarding the claim (generally, the claimant is allowed to submit such information within ten (10) business days).

ii) Within five (5) business days after the External Review is assigned to the IRO, the Plan will provide the IRO with the documents and information the Plan considered in making its Adverse Determination.

iii) If the claimant submits additional information related to the claim to the IRO, the assigned IRO must, within one (1) business day, forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the External Review. Reconsideration by the Plan will not delay the External Review. However, if upon reconsideration, the Plan reverses its Adverse Determination, the Plan will provide written notice of its decision to the claimant and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its External Review.

iv) The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo* (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit.

v) In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, recommendations or other information from your treating (attending) health care providers, other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

vi) The assigned IRO will provide written notice of its final External Review decision to the claimant and the Plan **within 45 days** after the IRO receives the request for External Review.

vii) If the IRO's final External Review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment

for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

viii) If the final External Review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If the claimant is dissatisfied with the External Review determination, he or she may seek judicial review as permitted under ERISA Section 502(a).

ix) The assigned IRO's decision notice will contain:

1) A general description of the reason for the request for External Review, including information sufficient to identify the claim (including the date or dates of service, health care provider, claim amount (if applicable), diagnosis code and its corresponding meaning, and treatment code and its corresponding meaning, and reason for the previous denial);

2) The date that the IRO received the request to conduct the External Review and the date of the IRO decision;

3) References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;

4) A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;

5) A statement that the IRO's determination is binding on the Plan (unless other remedies may be available to you or the Plan under applicable State or Federal law);

6) A statement that judicial review may be available to you; and

7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with External Review processes.

(b) **External Review of Expedited Urgent Care Claims**. The claimant may request an expedited External Review if:

i) The claimant. receives an adverse Initial Claim Appeal Benefit Determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize life or health, or would jeopardize the ability to regain maximum function, and the claimant has filed a request for an expedited internal appeal; or

ii) The claimant receives an adverse Appeal Claim Benefit Determination that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the claimant's life or health or would jeopardize the ability to regain maximum function; or, the claimant receives an adverse Claim Appeal Benefit Determination that concerns an admission, availability of care, continued stay or health care item

or service for which the claimant received emergency services, but you have not yet been discharged from a facility.

1. ***Preliminary Review for an Expedited Claim**.* Immediately upon receipt of the request for expedited External Review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described under Standard claims above). The Plan will immediately notify the claimant (e.g. telephonically, via fax) as to whether the request for review meets the preliminary review requirements, and if not, will provide or seek the information (also described under Standard Claims above).

2. ***Review of Expedited Claim by an Independent Review Organization (IRO)**.* Following the preliminary review that a request is eligible for expedited External Review, the Plan will assign an IRO (following the process described under Standard Review above). The Plan will expeditiously (e.g. meaning via telephone, fax, courier, overnight delivery, etc.) provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

    i) The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review, (described above under Standard Claims). In reaching a decision, the assigned IRO must review the claim *de novo* (as if it is new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law.

    ii) The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit.

    iii) The IRO will provide notice of their final expedited External Review decision, in accordance with the requirements set forth above under Standard Claims, as expeditiously as your medical condition or circumstances require, but in no event more than **seventy-two (72) hours** after the IRO receives the request for an expedited External Review. If the notice of the IRO's decision is not in writing, within forty-eight (48) hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

    iv) If the IRO's final External Review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

v) If the final External Review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If the claimant is dissatisfied with the External Review determination, they may seek judicial review as permitted under ERISA Section 502(a).

(6) When a Lawsuit May Be Started. No Employee, Dependent, beneficiary or other person shall have any right or claim to benefits under these Rules and Regulations or any right or claim to payments from the Fund, other than as specified herein.

(a) A claimant may not start a lawsuit to obtain benefits until after either: (1) the claimant has submitted a Claim pursuant to these Rules and Regulations, requested a review after an Adverse Benefit Determination for every issue deemed relevant by the claimant and a final decision has been reached on review; or (2) the appropriate time frame described above has elapsed since claimant filed a request for review and claimant has not received a final decision or notice that an extension will be necessary to reach a final decision. No legal action may be started or maintained more than two years after the date the claimant has been notified in writing that the denial of the claim has been confirmed on review.

(b) For any lawsuit filed, the determinations of the Trustees are subject to judicial review only for abuse of discretion.

(c) The provisions of this SECTION 8.05. shall apply to and include any and every claim to benefits from the Fund, and any claim or right asserted under the Plan or against the Fund, regardless of the basis asserted for the claim, and regardless of when the act or omission upon which the claim is based occurred, and regardless of whether or not the claimant is a "participant" or "beneficiary" of the Plan within the meaning of those terms as defined in ERISA. Such claim shall be limited to benefits due under the terms of the Plan, or to clarify his or her rights to future benefits under the terms of the Plan, and shall not include any claim or right to damages, either compensatory or punitive.

SECTION 8.06. Waiver of Class, Collective and Representative Actions**.** By participating in the Plan, to the fullest extent permitted by law, whether in court, Participants waive any right to commence, be a party to in any way or be an actual or putative class member of any class, collective, or representative action arising out of or relating to any dispute, claim or controversy, and Participants agree that any dispute, claim or controversy may only be initiated or maintained and decided on an individual basis.

SECTION 8.07. The Fund, at its own expense, will have the right and opportunity to examine the person of any Eligible Individual when and so often as it may reasonably require during the pendency of any claim, and also the right and opportunity to make an autopsy in case of death where it is not forbidden by law.

SECTION 8.08. The benefits provided by this Fund are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation.

SECTION 8.09. The provisions of the Plan are subject to and controlled by the provisions of the Trust Agreement, and in the event of any conflict between the provisions of the Plan and the provisions of the Trust Agreement, the provisions of the Trust Agreement will prevail.

SECTION 8.10. Privacy and Right to Receive and Release Necessary Information.

a. For the purpose of determining the applicability of and implementation of the terms of SECTION 7.03. through SECTION 7.04. dealing with Coordination of Benefits of this Plan or any provision of similar purpose of any other plan, the Plan may, to the extent consistent with Federal and state privacy laws (to the extent applicable) and the Plan's Privacy Procedures, release to or obtain from an insurance company or other organization or person any information, with respect to any person, that the Plan deems to be necessary for such purposes.

b. The Trustees and appropriate professionals retained by the Plan, may, to the extent necessary and in accordance with Federal and state privacy laws (to the extent applicable) and the Plan's Privacy Procedures, have access to such Protected Health Information regarding Participants and Dependents as is reasonably necessary to make eligibility, payment, claims and appeals decisions, or as otherwise necessary to the administration of the Plan.

c. The Trustees shall develop Privacy Procedures in accordance with The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable laws, and shall furnish to each Participant and Dependent a Notice of Privacy Practices. Such policies and practices shall be consistent with applicable Federal and state laws.

d. Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The following are permitted and required uses and disclosures of Protected Health Information, as that term is defined in HIPAA, that may be made by the Plan sponsor, the Board of Trustees.

   (1) The Board of Trustees may make the following permitted and required disclosures of Protected Health Information. All disclosures shall be of the Minimum Necessary information, as that term is defined under HIPAA, except in the case of Subsections (o) through (p) below.

      Permitted Disclosure Purposes:

      (a) As necessary for claims payment, Plan operations and treatment, including for the purpose of de-identifying information for further permitted disclosure.

      (b) Determining eligibility and amount of benefits.

      (c) Determining medical necessity, utilization reviews and precertifications.

      (d) Processing claims, auditing claims, investigating claims, responding to Participant inquiries regarding claims and ensuring proper claims payment.

      (e) Subrogation and other third-party recovery processing.

      (f) Determining proper employer contributions.

      (g) Processing and determining stop loss coverage.

      (h) Claims and appeals processing.

      (i) Quality assessment, case management, provider rating, underwriting (the Plan does not use or disclose PHI that is genetic information for underwriting purposes), enrollment and premium rating, patient safety activities and other related activities.

      (j) Legal and auditing services, including Plan compliance.

      (k) Plan design analysis, including cost analysis and Plan change evaluations.

(l) Implementation of HIPAA and other applicable laws.

(m) Tax and other regulatory filings.

(n) Disclosures to the covered individual.

(o) Disclosures that are subject to a specific written authorization from the covered individual.

(p) Uses that are incident to a use or disclosure otherwise permitted or required by law.

Required Disclosures:

(a) To the covered individual, when requested, to the extent required by law.

(b) When requested, to the Secretary of Health and Human Services;

(c) Any other instance in which HIPAA explicitly permits the use or disclosure without authorization.

(2) Further, the Board of Trustees will:

(a) Not use or further disclose the information other than as permitted or required by the Rules and Regulations and Privacy Procedures, or as required by law.

(b) Ensure that any agents to whom it provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Trustees with respect to such information.

(c) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan sponsor.

(d) 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.

(e) Make available Protected Health Information in accordance with HIPAA.

(f) Make available Protected Health Information for amendment by Participants and Dependents and incorporate any amendments to Protected Health Information in accordance with HIPAA.

(g) Make available the information required to provide an accounting of non-routine disclosures in accordance with HIPAA.

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services or any other officer or employee of HHS to whom the authority involved has been delegated for purposes of determining compliance by the Plan with the regulations requiring the Plan's Privacy Procedures and this Section.

(i) To the extent feasible, return or destroy all Protected Health Information received from the Plan that the Trustee(s) still maintain 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.

(j) Ensure the adequate separating required by the following SECTION 8.10.d.(3).

(3) The Board of Trustees and the Plan shall be treated as separate and distinct entities for purposes of these privacy rules. To that end, only the following persons or entities shall be authorized by the Trustees to have access to Protected Health Information and such access shall be solely for the specific Plan-related functions performed by such persons or entities.

(a) The Plan's administrator and its employees, including claims adjusters, benefits and eligibility staff, and accounting personnel.

(b) Utilization review and case management providers and their employees.

(c) Claims repricing provider and its employees, including health services purchasing coalitions.

(d) The Plan's business associates, including attorneys, actuaries, consultants and accountants.

(e) PPO organizations and stop loss carriers.

(f) Medical review consultants and firms.

(g) Prescription drug benefit providers.

(h) Dental and vision plan providers.

(i) Mental health and substance abuse treatment providers.

(j) Other service providers that require Protected Health Information to perform services for the Plan.

(k) Off-site storage providers who maintain the Plan's archival records.

(4) Noncompliance. In the event any person or entity to which the Plan has provided Protected Health Information in accordance with this Subsection d. uses or discloses such information in a manner inconsistent with the Plan, its Privacy Procedures, or applicable law, the Trustees shall have the right to:

(a) Notify such person or entity in writing of such violation and demand immediate correction and remedial measures be taken to correct such use or disclosure.

(b) Assess against such person or entity the actual costs of the corrective or remedial action described in Subsection (a).

(c) Send a letter of reprimand to any such person or entity that repeatedly commits such violations.

(d) Take such additional appropriate action including, to the extent feasible, terminating the Plan's relationship with such person or entity, or reporting such violations to the Secretary of Health and Human Services.

e. Security Regulations. The Board will implement measures to comply with the security regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160, 162 and 164 (the "Security Regulations"). The following provisions apply to Electronic Protected Health Information ("ePHI") that is created, received, maintained or transmitted by the Plan, except for ePHI that: (1) the Plan receives pursuant to an appropriate authorization (as described in 45 C.F.R. Section 164.504(f)(1)(ii) or (iii)), or (2) that qualifies as Summary Health Information and that it receives for the purpose of either (a) obtaining premium bids for providing health insurance coverage under the Plan, or (b) modifying, amending or terminating the Plan (as authorized under 45 C.F.R. Section 164.508).

The Board will, in accordance with the Security Regulations:

(1) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that the Plan creates, receives, maintains or transmits.

(2) Ensure that "adequate separation" is supported by reasonable and appropriate security measures. "Adequate separation" means the Plan will use ePHI only for Plan administration activities and not for employment related actions or for any purpose unrelated to Plan administration. Any Trustee, Plan professional, employee or other fiduciary of the Plan who uses or discloses ePHI in violation of the Plan's security or privacy policies and procedures or this Plan provision will be subject to the Plan's disciplinary procedures as described in SECTION 8.10.d.(4).

(3) Ensure that any agent or subcontractor to whom the Plan provides ePHI agrees to implement reasonable and appropriate security measures to protect the information.

(4) The Plan Administrator will report to the Board and Security Incident of which he becomes aware.

ARTICLE 9. AMENDMENT AND TERMINATION

SECTION 9.01. The Board has determined that each of the conditions, limitations and other terms of this Plan is essential to carry out the obligation of the Fund to provide comprehensive Hospital, medical and other benefits to all Retirees and eligible Dependents. In furtherance of that obligation the Board expressly reserves the right, in its sole discretion at any time, but upon a non-discriminatory basis:

a. To terminate or amend either the amount or condition with respect to any benefit even though the termination or amendment affects claims which have already accrued;

b. To alter or postpone the method or payment of any benefit; and

c. To amend or rescind any other provisions of the Plan.

ARTICLE 10. DISCLAIMER

SECTION 10.01. None of the benefits provided in the Plan is insured by any contract of insurance and there is no liability on the Board or any other individual or entity to provide payments over and beyond the amounts in the Trust Fund collected and available for that purpose.