MID-AMERICA
CARPENTERS BENEFITS

MID-AMERICA REGIONAL COUNCIL HEALTH FUND

NORTHERN ILLINOIS REGION

SUMMARY PLAN DESCRIPTION

EFFECTIVE MARCH 1, 2026

carpenterbenefits.org

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MID-AMERICA
CARPENTERS BENEFITS

A Message from the Trustees

It is very important that our Participants and family members are provided with quality, affordable health care. It's equally important that you know what benefits are available to you and how to use them to your best advantage — both financially and for your health.

This Summary Plan Description or SPD is given to all our Participants and their family members as a reference document and a resource you can use to become better acquainted with your benefits and the processes involved in using them. It is meant to be easy to read and understand. When we use the word "he," it refers to both genders throughout the SPD. We have tried to present the information in a straightforward and logical way.

While we have made an effort to explain things in everyday language, you may come across some words and phrases that have specific meaning within the context of the Plan. To help you identify them, they are bolded and italicized when first used and then capitalized throughout the rest of the SPD. You can find their definitions in the Glossary that starts on page 108.

As always, our Fund Office staff remains ready to serve you and your family, answering questions and providing updates on our benefits as they occur.

Here's to your very good health and wellness, now and in the future.

The Board of Trustees

If the language in this Summary Plan Description differs in any way from the official Plan Documents that legally govern the terms and conditions of the Health Fund, the official Plan Documents rule.

Timeliness of Mailed Items

Participants are responsible for allowing sufficient mailing time. The Fund is not responsible for USPS delays, incorrect processing dates, or missing/unreadable postmarks.

The United States Postal Service (USPS) may place processing dates or automated sorting marks on mail that do not reflect the actual date the item was mailed. Therefore, the Fund determines timeliness based on the date an item is received by the Fund Office, unless the Participant provides acceptable proof of the actual mailing date.

A Certificate of Mailing issued by the USPS will be accepted as proof of mailing. A Certificate of Mailing is an official USPS receipt that confirms the date a mail piece was presented and accepted for mailing by a USPS clerk. Each Certificate of Mailing is round dated ("postmarked") by USPS at the time the item is handed to the clerk, and the certificate is returned to the sender as the official receipt of mailing.

If a Participant provides a valid Certificate of Mailing showing that the item was mailed on or before the applicable deadline, the Fund, at its discretion, may use the Certificate Date to determine whether the submission was timely.

About this Booklet

This booklet provides you with a summary of the Active Plan of Benefits (the "Plan" or the "Active Plan") as of March 1, 2026, and replaces and supersedes any prior Summary Plan Descriptions (SPDs). It does not contain all Plan details. In determining any aspect of Plan coverage, the full provisions of the formal Plan Documents always govern.

You may obtain a copy of those documents by making a written request to the Plan Administrator. The Trustees reserve the right to change benefits in any way or terminate the Plan or any part of the Plan at any time, as allowed under law.

Highlights of eligibility requirements and Plan coverage along with the Schedule of Benefits begin on page 36. Plan highlights including these listed below start on page 49.

- Detailed benefits coverage;
- Limits and exclusions;
- What happens when you lose eligibility under the Plan;
- How to file Claims and appeals; and
- Other administrative Plan information.

Certain terms used in this document have specific meanings within the context of the Plan and are defined in the Glossary on page 108. You will notice that the first time they appear in the SPD they are bolded and italicized.

Notify Us If:

If you have a change in status, you must notify the Health Benefits Department at 312-787-9455 or update your information on the secure Member Portal, within 90 days of that change to update your information. Failure to report certain events could result in delayed eligibility status for your Dependents.

Changes in status include:

- Change of address;
- Marriage (you may also want to change your beneficiary);
- Changes in Dependent eligibility, or if you have a baby, adopt a child or become a stepparent;
- Death of a Dependent (you will also want to file a claim for Life Insurance benefits and/or change your beneficiary); and
- Adding or dropping other insurance coverage, including becoming eligible for coverage with Medicare or Medicaid.

You must notify the Health Benefits Department within 60 days of the following events, to avoid forfeiting continuation of coverage rights under COBRA:

- A divorce or legal separation; or
- When your Dependent child no longer meets the Plan's definition of a Dependent.

You will be required to provide documentation for the above changes. For more information on required documentation, see page 14.

The Health Fund (the "Fund") provides comprehensive health care coverage for you and your family through the Active Plan. The Fund contracts with professionals to offer you in-network access to quality care at reduced costs. Active Plan health benefits include:

- Comprehensive Medical Benefits, which include preventive care, Doctor Office Visits, Hospital care (inpatient and outpatient), Behavioral Health Treatment, Substance Use Disorder treatment, and hearing assessments. Comprehensive Medical Benefits are provided through a Network of providers administered by the Fund's Contracted Provider, BlueCross BlueShield of Illinois (BCBSIL).
- The Carpenters Center for Health, which offers access to health and wellness services.
- Prescription drug benefits are provided through the Express Scripts Inc. (Express Scripts) pharmacy network and specialty drug benefits are provided through Accredo Specialty Pharmacy.
- Access to vision benefits is offered through VSP's network of providers and the Carpenters Center for Vision.
- Access to dental benefits is offered through Delta Dental of Illinois.

In addition, the Active Plan includes:

- Short Term Disability benefits, which provide a weekly benefit if a Participant is Disabled due to an Illness or Injury and can't work.
- Maternity Leave benefits, which provide a weekly benefit for eligible pregnant Participants.
- Life Insurance benefits for you, your spouse and children.
- Accidental Death and Dismemberment (AD&D) Insurance benefits, as added financial protection for your family.
- A Health Reimbursement Arrangement (HRA), which can be used to pay out-of-pocket plan costs for you and your eligible Dependents such as Deductibles, Co-payments and Coinsurance, medical care expenses not covered or only partially covered under the Plan, and self-payments to continue coverage under the Plan.
- A Vacation Savings Plan, which is offered to offset your annual vacation expenses.

The benefits listed above apply to Participants who meet the eligibility requirements as described beginning on page 8. Apprentices have different eligibility requirements and coverage, depending on their contribution hours. See pages 8-9 for details.

The Active Plan Schedule of Benefits begins on page 36 and details the coverage offered. Page 7 lists the Contracted Provider for each benefit.

The Low-Cost Medical Plan Schedule of Benefits begins on page 44.

If you lose your eligibility for coverage under the Active Plan, various continuation of coverage options are available to you. See pages 84-94 for more details.

If you have questions about any of your benefits, contact the Health Benefits Department, Monday–Friday from 8:00 a.m. to 4:30 p.m. (CT) at 312-787-9455.

Important Contact Information

The chart below shows phone numbers and website addresses for the providers and administrators of the Mid-America Carpenters Regional Council Health Fund's benefit programs.

If You Have a Question or Need Information About	Service Provider Name	Phone Number / Website
Eligibility, Hospital or medical Claims status, adding or dropping Dependents, Continuation Coverage under COBRA or the Low-Cost Medical Plan	Fund Office – Health Benefits Department	312-787-9455 carpenterbenefits.org
Finding a Physician, Hospital or Surgi-Center in the BCBS PPO Network	BlueCross PPO Hospital & Physician Finder	800-810-2583 bcbsil.com
Appointments for services provided at the Health Center	Carpenters Center for Health, MCL Health Centers	312-337-4150 members.premisehealth.com/macrc
Member Assistance Program	Lyra Health	877-368-0644 carpenterbenefits.lyrahealth.com
Virtual Medical Care	MDLIVE	Phone: (888) 680-8646 Online: mdlive.com/bcbsil
Prescription drugs and the Mail Order Program	Express Scripts Inc.	800-939-2089 express-scripts.com
Specialty Pharmacy	Accredo Specialty Pharmacy	800-803-2523 accredo.com
Vision care	VSP Carpenters Center for Vision	630-598-5120 macrcvision.vspforme.com/
Dental care	Delta Dental of Illinois	800-323-1743 deltadentalil.com
Hearing aid instruments	EPIC Hearing Service Plan	866-956-5400 epichearing.com
Smoking Cessation Program	Pelago	877-349-7755 my.pelagohealth.com/carpenters
Continuation coverage under Self-Payment of Hours, COBRA, the Low Cost Medical Plan and related monthly payments	Fund Office – Health Benefits Department	312-787-9455 carpenterbenefits.org
Short Term Disability benefits, Life Insurance, AD&D and related Claim forms	Fund Office – Health Benefits Department	312-787-9455 carpenterbenefits.org
Health Reimbursement Arrangement (HRA)	Optum Financial	833-881-8156 my.optum.com/crcchra.html

The protection offered through the Mid-America Carpenters Regional Council Health Fund ("**Fund**") is designed to help keep you and your family in good health. Eligibility requirements determine when you and your family members are covered for benefits. Your ***Employer*** contributes to the Fund toward your coverage based on the number of hours you work, as required under a ***Collective Bargaining Agreement*** or ***Participation Agreement*** with the Fund. The number of hours you work in ***Covered Employment*** in a ***Calendar Quarter*** determines your initial eligibility for coverage. Thereafter, you must also work the required number of hours in each Calendar Quarter in Covered Employment to maintain eligibility for coverage.

Calendar Quarters	Coverage Quarters
Jan. 1st – Mar. 31st	June 1st – Aug. 31st
April 1st – June 30th	Sept. 1st – Nov. 30th
July 1st – Sept. 30th	Dec. 1st – Feb. 28th/29th
Oct. 1st – Dec. 31st	Mar. 1st – May 31st

Initial Eligibility

You are eligible for benefits on the first day of the Coverage Quarter following one, but not more than two consecutive ***Calendar Quarters*** during which you have a total of 500 hours contributed to the Fund on your behalf by one or more ***Contributing Employers***.

Initial Eligibility for Apprentices: As an apprentice in the Mid-America Carpenters Regional Council Apprentice and Training Program ("***Apprentice Program***") who is enrolled in the Apprentice Program's training school, you are eligible for apprentice reduced coverage (which does not include prescription drug or dental benefits) on the first day of the Coverage Quarter following one, but not more than two consecutive Calendar Quarters during which you have a total of 400 hours contributed to the Fund on your behalf by one or more Contributing Employers. Full ***Active Plan*** benefits (which include prescription drug and dental benefits) are available to an apprentice if a total of at least 500 hours of ***Contributions*** have been paid to the Health Fund on your behalf.

NOTE: Initial eligibility for the Active Plan or apprentice reduced coverage may not be satisfied by Self-Payment of Hours (page 86).

Initial Eligibility Examples *The following examples assume that your employer has paid and the Fund Office has received contributions on your behalf.*	
Example 1: John Smith began working for XYZ Construction on April 15. He worked 164 hours in April, 175 hours in May, and 168 hours in June. As Mr. Smith worked 507 hours in one Calendar Quarter, he becomes eligible for benefits during the Coverage Quarter of September 1st through November 30th.	***Example 2***: Frank Jones began working for XYZ Construction on April 15. He worked 54 hours in April, 120 hours in May, 80 hours in June, 94 hours in July, 112 hours in August and 84 hours in September. Mr. Jones did not work as many hours in the Calendar Quarter of April through June as Mr. Smith in Example 1, he did, however, work 544 hours in two Calendar Quarters. Therefore, Mr. Jones becomes eligible for benefits during the Coverage Quarter of December 1st through February 28/29th.

NOTE: Upon initial eligibility, you are required to complete an Enrollment Form and Beneficiary Designation Form. These forms are available on the Fund's website at ***carpenterbenefits.org*** or by mail or email (*submit@macbenefits.org*) from the Fund Office. Contact the Health Benefits Department at 312-787-9455, for details.

Monthly Eligibility for Non-Bargained Contractor Office Employees

In accordance with the terms of the applicable Participation Agreement, certain non-bargained Office Employees of signatory contractor Employers, and their enrolled Dependents, may be covered provided that the Employer makes the required contribution for coverage. Coverage is effective on the first day of the month following the month in which the first required contribution is received. These non-bargained contractor Office Employees are not eligible for Short Term Disability Benefits, Maternity Leave Benefits, Life Insurance Benefits, Accidental Death & Dismemberment Benefits, HRA Benefits, Vacation Savings Plan benefits, the Retiree Plan of Benefits, or extension of Active Plan Benefits through Self-Payment of Hours.

Maintaining Eligibility

You must continue to work at least 300 hours per Calendar Quarter in Covered Employment and/or receive credit of hours under Short Term Disability to meet the 300-hour requirement to maintain eligibility during the next Coverage Quarter. If you do not have 300 hours but have credit for at least 1,200 contribution hours in Covered Employment and/or a credit of hours under Short Term Disability to meet the 1,200-hour requirement in the current and the three immediately preceding Calendar Quarters, you will remain eligible for benefits for the next Coverage Quarter.

You may also maintain eligibility for full Active Plan coverage through Self-Payment of Hours if certain criteria are met (see page 85).

An apprentice must maintain enrollment in the Apprentice Program and work at least 200 hours per Calendar Quarter in Covered Employment and/or receive credit of hours under Short Term Disability to meet the 200-hour requirement to maintain eligibility for apprentice reduced coverage during the next Coverage Quarter. If an apprentice does not have 200 hours but has credit for at least 960 Contribution hours in Covered Employment and/or a credit of hours under Short Term Disability to meet the 960-hour requirement in the current and the three immediately preceding Calendar Quarters, he will remain eligible for apprentice reduced coverage for the next Coverage Quarter. Apprentice reduced coverage does not include prescription drug or dental benefits. If you are dropped from the Apprentice Program, you are no longer eligible for apprentice reduced coverage.

You may also maintain eligibility for apprentice reduced coverage (or full Active Plan coverage if you are currently eligible for such coverage) through Self-Payment of Hours if certain criteria are met (see page 85). You may not increase your current level of coverage through Self-Payment of Hours. If you are dropped from enrollment in the Apprentice Program, you may only maintain your current level of Plan coverage through Continuation Coverage under COBRA (see page 87).

The ***Trustees*** reserve the right to change, modify or discontinue all or part of the eligibility rules at any time with written notice in accordance with federal law.

If You Lose Eligibility

If you lose your eligibility for coverage under the Active Plan, various continuation of coverage options are available to you. See pages 84-94 for more details.

Reinstatement of Eligibility

If you lose eligibility for benefits because you have not worked the required number of hours or your Employer failed to remit Contributions on your behalf, you may again become eligible on the first day of the Coverage Quarter following a Calendar Quarter in which contributions for at least 300 hours (200 hours for apprentices) are made on your behalf.

However, if you return to work after being away longer than 12 consecutive Calendar Quarters (three years), with no Contributions paid on your behalf, you must again meet the initial eligibility requirements as stated in the section titled Initial Eligibility on page 8.

For information regarding reinstatement of eligibility following a period of Military Service, see Continuation of Group Health Coverage under USERRA on page 92.

Quarterly Eligibility Report

Prior to the beginning of each Coverage Quarter, your "Quarterly Eligibility Report" is made available through the secure Member Portal on our website. The report tells you:

- Whether or not you are eligible for benefits during the next Coverage Quarter;
- The number of hours that have been paid to the Fund on your behalf by one or more Contributing Employers;
- The month/year that the hours represent; and
- A four Calendar Quarter hour total.

You may log into the Member Portal at any time to review this information. In addition to checking to see whether you are eligible for the upcoming Coverage Quarter, you should also verify that the hours contributed match your work history.

Discrepancies

If there is any difference between the hours you worked and the hours reported by your Employer(s), you should immediately report the discrepancy to the Fund Office Employer Contributions Department. You will need to provide supporting documentation, such as copies of pay stubs. The Fund Office will contact the employer(s) to find out the reason for the difference and attempt to collect any missing contributions. Once the Fund receives the corrected contributions, your eligibility record will be retroactively adjusted.
Your failure to report discrepancies to the Fund Office may result in the loss of hours of Covered Employment causing a loss of eligibility.

Reciprocal Agreements

You may be able to receive credit for hours you work for Employers that contribute to an "out-of-area" fund instead of this Fund (your "home fund") if those funds have entered into a reciprocal agreement with this Fund, or if they participate in The United Brotherhood of Carpenters *International Reciprocal Agreement*. Contact the Contributions Department at 312-787-9455, as soon as possible to get started on the appropriate paperwork if you want to transfer your hours.

Important: Before the hours can be credited, the Fund Office must receive the hours and contributions from the out-of-area fund. Some areas have a lower contribution rate than the Health Fund (your home fund); therefore, you may not receive an hour-for-hour transfer.

Are You Working Out of the Area?

If you are working out of the jurisdiction of this Fund, it is your responsibility to:

- Notify the Contributions Department at the Fund Office at 312-787-9455 before you begin working out of the area, so a Reciprocal Transfer of Hours Request Form can be sent to you.
- Complete the Reciprocal Transfer of Hours Request Form and mail it back to the Contributions Department at 12 E. Erie St., Chicago, IL 60611.

Once the Contributions Department receives your completed Reciprocal Transfer of Hours Request Form, it will be sent to the reciprocating fund to advise them that you want your hours transferred to the Mid-America Carpenters Regional Council Health Fund. Only when payment from the reciprocating fund is received by the Contributions Department will you receive credit for the hours you worked.

Important Note:

- Some out-of-area funds have a lower Contribution rate. Therefore, you may not receive an hour-for-hour credit. It is possible that you will receive a percentage of the hours worked based on the Contributions received.
- It generally takes at least two months for the Contributions Department to receive a transfer of Contribution hours. For example, your work performed in the month of June should be paid by your Employer in the month of July; however, hours information and Contributions generally will not be transferred to this Fund until August. If the Employer is delinquent in making payment, credit for your hours may be further delayed.

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

You become eligible for Life and AD&D coverage the first day you meet the eligibility requirements under the Active Plan.

Eligibility for Short Term Disability

You become eligible for Short Term Disability coverage the same day you become eligible for medical coverage under the Active Plan.

Eligibility for Retiree Benefits

Contact the Retirement Benefits Department for help with the retirement process and any questions you may have about your eligibility for health care benefits under the Retiree Plan of Benefits. To inquire about your eligibility for retirement health benefits or to obtain a Retiree Health Plan SPD, call 312-787-9455, or visit the Fund's website at ***carpenterbenefits.org***.

Dependent Eligibility

If you are eligible for benefits under the Active Plan, your eligible spouse and children are automatically covered provided you submit the required forms and documentation, as described on page 14. An individual cannot be covered as both an ***Employee*** and a ***Dependent*** child or as both a spouse and a Dependent child under the Plan to the extent permitted by law.

A minor Dependent child is a child from birth through age 18. An adult Dependent child is a child age 19 and older.

The following individuals are considered eligible Dependents under the Plan:

- Your lawful spouse, as recognized under applicable state law and for whom all required documentation is submitted, if not legally separated or divorced from you;
- Your biological child through the end of the calendar month in which the child attains age 26;
- Your adopted child or a child placed in your home for legal adoption (before attaining the age of 18) through the end of the calendar month in which the child attains age 26; and
- Your child with a physical or mental disability who is unmarried and age 26 or older, if:
  - The child was covered by the Plan upon reaching age 26;
  - The disability is considered permanent and began either:
    - » prior to the child attaining age 26, while the child was covered as a Dependent under this Plan, and proof of such is provided to the Health Benefits Department; or
    - » at birth and the child was covered by this Plan for at least five consecutive years before attaining age 26;
  - The child is chiefly dependent on you for more than 50% of the child's financial support and maintenance during the ***Calendar Year*** and proof of such is provided to the Health Benefits Department;
  - The disability is a severe physical or mental impairment that causes the child to be incapable of self-support; and
  - The child qualifies as your "qualifying child" or "qualifying relative" within the meaning of Internal Revenue Code Section 152(c) or (d).

The Trustees may periodically require you to submit evidence that your child continues to meet the disability criteria above. If you fail to provide such evidence, your Dependent's coverage may be terminated.

- Your unmarried stepchild through the end of the calendar month in which he turns age 26, who is in a regular parent-child relationship with you, for whom you provide more than 50% of financial support for the Calendar Year and who lives with you for more than one-half of the Calendar Year. The residency requirement does not apply to disabled adult Dependent stepchildren.
  A stepchild must be a child of your current spouse who was born to your spouse or legally adopted by your spouse before your marriage.
  As requested, you must provide proof of your stepchild's eligibility to the Health Benefits Department.
  Primary coverage by this Plan for stepchildren is provided only if no other person is obligated to provide insurance and no other insurance is available through biological or adoptive parents.
  Coverage for stepchildren terminates the last day of the month of the divorce, death or legal separation from the Covered Individual.
- Your eligible child who is named as a dependent under a ***Qualified Medical Child Support Order (QMCSO)*** or National Medical Support Notice (see page 83 for more information on QMCSOs).
  Note that a child, regardless of age, is not considered an eligible Dependent if he is serving full time in the Military Service, to the extent permitted by law.

The Plan provides temporary coverage for certain guardianship dependents when another Health Fund merges into the Health Fund. If a merging Health Plan provided coverage for a child under court ordered guardianship, and that child was covered on the day before the merger, the Health Fund will treat the child as an eligible Dependent for up to 12 months starting on the effective date of the merger (or until the child reaches age 26, if earlier). This transitional coverage is intended to give families time to pursue adoption or secure other coverage. Coverage will end after the 12-month period unless the child otherwise qualifies as a Dependent under Plan rules.

How to Enroll Eligible Dependents

Within 90 days from the date of your initial eligibility, and from time to time as required by the Trustees, you must complete all required forms and provide supporting documentation about your Dependents' eligibility for coverage to the Health Benefits Department. See Furnishing Required Information and Documentation below.

If you don't supply required documents to the Health Benefits Department within 90 days, your Dependents' coverage will take effect beginning on the first day of the month after the Health Benefits Department receives all required documentation.

If you have a baby, adopt a child or have a child placed with you for adoption, you must submit to the Health Benefits Department the required documentation proving your Dependent child's status within 90 days of the event. If you don't supply proof of Dependent status within 90 days, coverage will be terminated. Once the Health Benefits Department receives the required documentation, coverage will be reinstated effective the date the Health Benefits Department receives all the required documentation.

Furnishing Required Information and Documentation

Every Covered Individual shall, upon reasonable request, furnish the Board of Trustees such information or proof as may be reasonably necessary or helpful in determining eligibility or benefit payments. Failure on the part of the Covered Individual to comply with any request for information shall be grounds for denying or discontinuing benefits to such Covered Individual until the request is complied with. Document requirements change from time to time.

Please call the Health Benefits Department at 312-787-9455 with questions.

Dependent	Examples of Proof of Dependent Status
Spouse	• County-certified marriage certificate
Child	• County-certified birth certificate
Child for whom court order mandates coverage	• County-certified birth certificate • Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice • County-certified divorce decree (if the parents are divorced)
Newly adopted child	• Interim order of placement and/or final adoption order
Stepchild	• County-certified birth certificate • County-certified divorce decree (if the parents are divorced) or a stepchild dependent affidavit or a death certificate of the biological parent

Note: Church marriage certificates and Hospital birth announcements are not acceptable forms of proof.
You may obtain a copy of the Plan's QMCSO procedures free of charge from the Health Benefits Department or visit the Fund's website at ***carpenterbenefits.org***.

Health Reimbursement Arrangement Benefits

The Board of Trustees has established a ***Health Reimbursement Arrangement*** benefit, also known as a Health Reimbursement Account (HRA), for Employees who are working for an Employer who contributes to the Plan by means of a Collective Bargaining Agreement and/or Participation Agreement.

Under an HRA, you have a personal balance which accumulates based upon the number of hours you work as long as your Employer makes the required Contributions to the Health Fund on your behalf. You can use the balance in your HRA for out-of-pocket Plan costs for you and your eligible Dependents such as:

- ***Deductibles***;
- Emergency Room or prescription drug ***Co-payments***;
- ***Coinsurance***;
- Medical care, dental or vision expenses not covered by the Plan; and
- Self-payments to continue health care coverage under the Active Plan

You may also want to consider allowing funds to accumulate for later use when you retire.

How an HRA Works

Qualified medical or premium expenses are reimbursed to you tax-free and any unused amounts in your HRA will be carried forward for reimbursements to you in later years. For a complete list of IRS qualified medical and premium expenses, please see IRS Publication 502, Medical and Dental Expenses, at ***irs.gov/publications/p502***.

An account will be set up and maintained for you, funded by monthly contributions for the hours that you work and paid by your Employer, at a rate established pursuant to a Collective Bargaining Agreement or Participation Agreement.

Reimbursement is only available to the extent of Employer Contributions credited to your account (and reduced by prior reimbursement payments). If you die, your Dependents can receive reimbursement of eligible expenses from your HRA as long as they remain eligible under the plan. No death benefits or transfers from the account are permitted.

It is important to note that you cannot make self-payments into your HRA. Also, credit of hours while on Short Term Disability benefits and hours paid by the Employee through Self-Payment of Hours do not count towards HRA funding.

Freezing and Forfeiture of Accounts

Unlike a retirement plan, the HRA is not a vested benefit. You must be a ***Member in Good Standing*** with your local union (your dues must be current and not in arrears) to utilize your account. If you are not, your account will be frozen until you return to the Member in Good Standing status. If you do not return to this status within 12 months, your account is permanently forfeited to the Plan.

Your HRA account will also be permanently forfeited to the Plan:

- If you are an apprentice and you are dropped from the Apprentice Program.
- If you die and are not survived by Dependents.
- If your HRA balance is less than the minimum required balance set by the Trustees from time to time ($100 as of January 1, 2026), and no new contributions are received or no withdrawals are made for 24 consecutive months.

You may elect to freeze your HRA account annually, if you lose eligibility under the Plan and if you become eligible for Retiree Plan. Upon your death, your surviving covered Dependents may also freeze your HRA account. Your account will automatically be frozen if you fail to provide the substantiation required by IRS rules.

HRA Benefits After You Retire

As you will most likely not be working for a Contributing Employer after you retire, your account will no longer be funded; however, as long as you remain a Member in Good Standing with your local union (your dues must be current and not in arrears), you may continue to access your HRA for reimbursement of retiree health care premiums and other eligible expenses.

For more information or if you have questions about your HRA, contact Optum Financial at 833-881-8156. Service Representatives are available 24 hours a day, seven days a week. Or, visit ***my.optum.com/crcchra.html***.

Vacation Savings Plan Benefit

The Trustees have established a Vacation Savings Plan for Employees who work for an Employer who contributes post-tax vacation savings contributions to the Plan.

How the Vacation Savings Plan Works

The vacation savings contributions will accumulate in your Vacation Account during the Plan Year based on the formula set forth in the Collective Bargaining Agreement. The amounts accumulated in your Vacation Account are used to fund a vacation benefit for you.

You are not permitted to contribute additional amounts to your Vacation Account and vacation savings contributions are not subject to reciprocity.

Payment of Benefits

Amounts accumulated in your Vacation Account will be paid to you annually no later than July 31 each year. The payment will include all contributions made on or before June 30th of each year.

You should submit an election form each year for the manner in which you would like to receive your benefit payment: via direct deposit or mailed check. A distribution fee applies to benefits distributed by mail. If you fail to timely submit an election form, your benefit will be mailed to you at the address on record with the Fund Office.

Unclaimed Benefits

The Fund has adopted appropriate procedures to regularly review when a check is returned or is unclaimed. If after exhausting these procedures the Fund is unable to locate you or deliver the check, the payment will be temporarily forfeited. If you contact the Fund Office and request distribution, the Fund will re-issue the payment.

If you fail to keep your address information up-to-date or provide valid bank deposit routing instructions, the Fund will stop distributing your benefit until the necessary information is provided. The Fund will follow similar procedures, including temporary forfeitures, for checks that are delivered but not negotiated. The Fund may issue a stop pay order where necessary.

To keep you and your family healthy and well, the Plan provides comprehensive coverage for medical care due to ***Illness*** or ***Injury*** that did not occur on the job. The Plan covers preventive care to the extent required under the ***Affordable Care Act (ACA)*** at 100% if a BCBS PPO Provider is used.

For more details, refer to page 36 for the Active Plan Schedule of Benefits, or page 44 for the Low-Cost Medical Plan Schedule of Benefits.

How Comprehensive Medical Benefits Work

The Plan contracts with **BlueCross BlueShield of Illinois (BCBSIL)** to offer a ***Preferred Provider Organization (PPO)***. Using a PPO Provider saves you and the Fund money, because these contracted providers agree to a discounted rate for services. This means charges from a PPO Provider, ***Doctor*** or ***Hospital*** are discounted, so you and the Fund share the cost of a lower ***Negotiated Rate***, and you and the Fund pay less for health care.

Through BCBSIL, you also have access to the Wellbeing Management mental health PPO network. Wellbeing Management also offers chronic condition management opportunities through a certified health coach.

You may find a PPO Provider in your area by calling BCBSIL at 800-810-2583 or by visiting their website at ***bcbsil.com*** (in Illinois) or ***bcbs.com*** (out-of-state).

If your PPO Provider leaves the PPO network, you may be eligible for a transition period to find a new PPO Provider. Contact the Health Benefits Department at 312-787-9455, if you think you may be eligible for this continuity of care benefit.

Example: Compare what John pays when using a PPO Hospital versus a Non-PPO Hospital. This example assumes that John has already met the PPO and Non-PPO deductibles.		
	PPO Hospital	***Non-PPO Hospital***
Expenses charged for a two-day hospital stay	$5,000 billed charges $2,500 (PPO discounted rate)	$5,000 billed charges $4,000 (Reasonable and Customary Allowance)
Plan pays	$2,000 (80% of PPO discounted rate)	$2,400 (60% of Reasonable and Customary Allowance)
John pays	$500 (20% of PPO discounted rate)	$2,600 (40% of Reasonable and Customary Allowance, plus difference between provider's charge and Reasonable and Customary Allowance)
Bottom line: John saves $2,100 by using a PPO Hospital.		

Deductible

You (and each of your covered Dependents) must first meet a Calendar Year Deductible before the Plan will begin to pay benefits for certain ***Covered Services***. This means you are responsible for paying for charges in full up to the Deductible amount.

The Deductible does not apply to preventive care, hearing, prescription drug or vision benefits.

There is a separate Deductible for dental services, as shown on the *Schedule of Benefits*. The Comprehensive Medical Benefit Deductible and the Deductible for dental services cannot be combined.

Family Deductible: A family Deductible applies when three or more family members' ***Covered Expenses*** accumulate to meet the family Deductible. Once the family Deductible is met, all family members are considered to have met their Deductible.

Separate PPO and Non-PPO individual and family Deductibles: The Plan has a separate PPO Deductible and Non-PPO Deductible. This means that charges you incur from a PPO Provider count only toward meeting your PPO

Deductible. If you use a Non-PPO Provider, you must meet a separate Non-PPO Deductible. However, charges for ***Protected Services*** count toward the PPO Deductible. The two Deductible amounts cannot be combined.

Deductibles from the Active Plan do not transfer to or from the Low Cost Medical Plan or the Retiree Plan. In addition, Deductibles do not transfer if a Dependent becomes an Employee or if an Employee becomes a Dependent, or if a Dependent child becomes a Dependent spouse or if a Dependent spouse becomes a Dependent child.

Deductible carryover: Any Covered Expense applied to the Deductible in October, November or December of the Calendar Year will apply toward meeting the Deductible for the next Calendar Year.

What's not included in the Deductible: ***Emergency Room Co-payment*** (***Co-pay***), Coinsurance amounts, amounts you are charged above the ***Reasonable and Customary Allowance*** for ***Out-of-Network*** services, amounts you pay for hearing and vision care and excluded services do not count toward the Comprehensive Medical Benefit Deductible.

Dental coverage has a separate Deductible.

Coinsurance and Co-payments

The Coinsurance amount is your share of the cost of Covered Services after you have satisfied the Calendar Year Deductible. Coinsurance amounts are only applicable to expenses covered by the Plan. Each year, after you satisfy the Calendar Year Deductible (either individual or family), the Plan generally pays a percentage of Covered Charges and you pay your share, up to the Out-Of-Pocket Maximum. See Out-of-Pocket Maximum below.

A Co-payment is a flat dollar amount. For example, when you go to the Emergency Room you may pay a Co-payment in addition to your Deductible and/or Coinsurance. Co-payments do not apply to the Deductibles.

Refer to the *Schedule of Benefits* for the Active and Low Cost Medical Plans on pages 29 – 47 for individual and family PPO and Non-PPO Calendar Year Deductibles and Out-of-Pocket Maximums.

Out-of-Pocket Maximum

Once you meet the Deductible, the Plan will begin to pay benefits for Covered Services. Your portion of the cost of Covered Services is limited by the Plan's annual Out-of-Pocket Maximum.

This means that once you meet the annual Out-of-Pocket Maximum, the Plan will pay for ***Covered Medical Expenses*** at 100% for the rest of the Calendar Year.

There are individual and family Out-of-Pocket Maximums that apply when you receive care from a PPO Provider. This means three or more covered family members' expenses can be combined to meet a family Out-of-Pocket Maximum.

Out-of-Pocket Maximums from the Active Plan do not transfer to or from the Low-Cost Medical Plan or the Retiree Plan. In addition, Out-of-Pocket Maximums do not transfer if a Dependent becomes an Employee or if an Employee becomes a Dependent, or if a Dependent child becomes a Dependent spouse, or if a Dependent spouse becomes a Dependent child.

Separate PPO and Non-PPO Out-of-Pocket Maximums: There is also a separate, higher Out-of-Pocket Maximum when you use a Non-PPO Provider. This means that charges you incur from a PPO Provider count only toward meeting your PPO Out-of-Pocket Maximum. If you use a non-PPO provider, you must first meet a separate Non-PPO Out-of-Pocket Maximum before the Plan will pay 100% of Covered Expenses for the rest of the Calendar Year. However, charges for Protected Services count toward the PPO Out-of-Pocket. The two Out-of-Pocket Maximums are not combined

Separate Out-of-Pocket Maximums for Comprehensive Medical and Prescription Drug Benefits: There are Out-of-Pocket Maximums for prescription drug benefits and specialty pharmacy prescription drug benefits that are separate from the Out-of-Pocket Maximums for Comprehensive Medical Benefits. This means that charges you incur from prescription drug Co-payments count only toward meeting your prescription drug Out-of-Pocket Maximums and do not count toward the Comprehensive Medical Benefit Out-of-Pocket Maximum.

Some expenses are not applied to the Comprehensive Medical Benefits Out-of-Pocket Maximum, including:

- Co-pays for prescription drugs;
- Vision and dental expenses;
- Amounts above the Plan's Reasonable and Customary Allowance for covered Non-PPO Medical Expenses;
- Expenses not considered Covered Medical Expenses; and
- Amounts in excess of a benefit maximum or lifetime maximum for non-essential benefits, as described under the Affordable Care Act.

Hospital Recovery Incentive Program

If you find and correct overcharges on your inpatient Hospital bill, you can earn a reward of up to 25% of the savings up to $500 maximum in a Calendar Year.

Overcharges that total less than $25 and Physician charges do not apply to the Hospital Recovery Incentive Program.

Call the Health Benefits Department at 312-787-9455 for additional information if you believe your bill contains erroneous charges.

Preauthorization

The Plan requires preauthorization for certain services, including:

- Inpatient admissions for:
  - Hospital
  - Rehabilitation
  - Skilled nursing
  - Long-term acute/subacute care
  - Bariatric surgery
- Outpatient procedures:
  - Spinal cord stimulation
  - Artificial intervertebral disc
- Behavioral Health services:
  - Residential treatment
  - Partial hospital programs
  - Intensive outpatient programs
  - Applied behavioral analysis treatment
  - Outpatient electroconvulsive therapy
  - Repetitive transcranial magnetic stimulation (rTMS)

Your provider will usually obtain approval directly from BCBSIL for the service or procedure. However, it is your responsibility to make sure your service, or procedure is approved before it takes place (except in an emergency). Failure to obtain preauthorization could result in delayed payment or denial of the claim. You can check whether a service or procedure requires preauthorization and the status of a preauthorization request by calling 800-255-5192 for medical services or 800-851-7498 for Behavioral Health services.

The Carpenters Center for Health

The **Carpenters Center for Health ("Health Center")** is a health care facility in partnership with Premise Health, a nationwide manager of onsite health clinics. The Health Center offers a range of primary and urgent care services at no cost to you and your eligible Dependents (age two and older), provided you meet the Plan's eligibility requirements.

To take advantage of the services provided at the Health Center, you must be eligible for and enrolled in Comprehensive Medical Benefits under the Active Plan or the Low-Cost Medical Plan.

Using the Health Center

It is best to have a scheduled appointment when visiting the Health Center, even if you want to be seen the same day. You can either call 312-337-4150 or schedule online through the Health Center's patient portal, atmembers.premisehealth.com/MACRC. The Patient Portal is a secure online tool that houses your electronic health records and enables you to make appointments, review lab results, communicate with your healthcare team and more. All your personal information is private and secure.

Health Center Services

Services available through the Health Center are provided at no cost to you, and include, but are not limited to:

- Primary care services;
- Preventive care services;
- Acute/urgent care services;
- Clinical laboratory services, including diagnostic tests performed onsite and specimen collection and diagnostic testing for routine Physician-ordered tests sent by the Health Center to a qualified offsite laboratory;
- Disease management services for chronic diseases and conditions, including onsite Physician services and counseling;
- Physical therapy;
- Chiropractic services;
- Behavioral Health counseling; and
- Health and wellness services, including but not limited to, biometric testing, health risk assessments and education and counseling for disease prevention and wellness promotion.

Carpenters Center for Health	Hours of Operation
4979 Indiana Avenue, 3rd Floor Lisle, IL 60532-3847 312-337-4150 ***members.premisehealth.com/MACRC***	M, W, F - 8:00 a.m. to 5:00 p.m. (CT) T, Th - 10:00 a.m. to 7:00 p.m. (CT)

The Health Center does not have a full-service onsite pharmacy; however, it carries a variety of common generic medications onsite for treatment of an acute Illness such as sinus infection, strep throat, etc. Additionally, limited starter generic medications will be provided onsite as part of your visit to the Health Center in support of disease/condition management (such as a cholesterol-lowering drug for a diagnosis of high cholesterol).

The Health Center's staff can prescribe medications and send them to your local pharmacy for pick-up or electronically submit to the Express Scripts Mail Order Program. Normal Co-payments will apply. Controlled substances, including narcotics, are not dispensed at the Health Center.

Health Center services do not include:

- Services for Dependents younger than age two;
- Services covered under any Workers' Compensation law, Employers' Liability law, Occupational Diseases Law or any similar law, except as may be covered under the Plan's acute/urgent care services;
- Services covered by any other liability insurance; and
- Services subject to subrogation, unless the Covered Individual has entered into a reimbursement agreement with the Plan. (See page 97.)

Prescription Drug Benefits

Prescription drugs can play an important role in your overall health. Recognizing this importance, the Plan provides comprehensive prescription drug coverage that is designed to help you pay for the medications you need. Prescription drug benefits are not available to an apprentice except as described in the section titled Eligibility on page 8.

About Your Prescription Drug Coverage

Benefits for prescription drugs depend on whether the prescription is for a generic, single- or multi-source brand-name medication, and whether a brand-name medication has a generic substitute available. A single-source brand-name drug is one where there is currently no generic drug available as a substitute. A multi-source brand-name drug is one where there are one or more generic drugs available. If you need a specialty medication, one that is used to treat complex chronic or rare medical conditions, the Plan provides benefits for those drugs as well. The Plan has contracted with two ***Networks*** to provide you access to affordable prescription drug therapy.

For most prescriptions, the Fund's Contracted Provider is ***Express Scripts Inc. (Express Scripts)***. Express Scripts offers an extensive retail Network of pharmacies and a Mail Order Program (Home Delivery Program). You can contact Express Scripts at 800-939-2089 or visit express scripts.com.

Out-of-Pocket Maximums for prescription drugs: The Plan maintains a limit on the amounts a Covered Individual pays out-of-pocket for prescription drugs in a Calendar Year. See page 36 of the Active Plan Schedule of Benefits or page 44 of the Low-Cost Medical Plan Schedule of Benefits.

Retail Pharmacy Program

You can use your Express Scripts ID card to fill prescriptions at any participating Express Scripts pharmacy. When you use your ID card, there are no Claims for you to file. Consider generics whenever possible as they will save you money.

For more details, refer to the Active Plan Schedule of Benefits, or the Low Cost Medical Plan Schedule of Benefits.

On the rare occasion that you use a pharmacy that is out of the Contracted Provider's Network, you are required to pay the full cost of the drug at the retail pharmacy. You may then submit a claim to Express Scripts. Reimbursement is based on the discounted amount Express Scripts would have paid to a participating pharmacy for that drug.

Important: Prescription drug benefits are not included in apprentice reduced coverage.

Quantity Limits for Short Term Medications at Retail Pharmacies

Retail pharmacies can fill up to a 30-day supply of your medication (or 100 units, whichever is less). This limit applies to all short term or one-time prescriptions.

Long Term Medications - Mail Order Program or Walgreens Retail Pharmacy

If you take Long Term Medications for chronic conditions such as high blood pressure, diabetes, arthritis, or asthma, you are required to use either the Mail Order Program or a Walgreens retail pharmacy.

If your Doctor prescribes a Long-Term medication, ask for two prescriptions:

- one for a 30-day supply, and
- one for a 90-day supply (with refills)

You may fill the 30-day prescription at any participating retail pharmacy. Use the 90-day prescription through the Mail Order Program or at Walgreens.

Refill Limits for Long Term Medications

If you do not fill your Long-Term Medication through the Mail Order Program or at Walgreens retail pharmacy, the Plan will only cover:

- the initial fill, and
- up to two refills

After the third fill, you must switch to the Mail Order Program or Walgreens to continue receiving benefits. For more information about the Mail Order Program, contact Express Scripts at 800-939-2089 or visit ***express-scripts.com***.

Extended Care/Skilled Nursing Facility Exception

The Fund Office will make an exception to the mandatory Mail Order Program/Walgreens requirement for long term medications Program if you are or your eligible Dependent is a resident of an Extended Care/Skilled Nursing Facility and the facility is unable to use the Mail Order Program. You must provide documentation verifying residency and stating the specific reason why the facility is unable to utilize Express Scripts' Mail Order Program.

Preferred Drug Step Therapy Program

The Plan also provides for a Preferred Drug Step Therapy Program that identifies generic or brand medications in certain drug classes and recommends FDA-approved lower-cost generic options to the brand-name medication. If your Doctor prescribes a non-preferred brand, you will need to switch to a generic or preferred brand for the Plan to cover the medication. In certain cases, if your Doctor believes you cannot switch medications, he can request a coverage review by contacting Express Scripts.

Formulary

The Plan participates in Express Scripts' National Preferred Formulary. The formulary is a broad list of preferred medications used by Express Scripts clients nationwide. The formulary is subject to change from time to time. In the event that your medication is removed from Express Scripts' formulary, they will notify you in advance and inform you of alternative drugs available to you in the same therapeutic class. Medications not on the National Preferred Formulary are
not covered by the Plan.

Specialty Medications

The Plan has contracted with ***Accredo Specialty Pharmacy (Accredo)*** for specialty medications used to treat chronic and rare conditions. Specialty medications may include oral, injectables and infusion therapy, which often require special handling.

Specialty medications are generally dispensed in 30-day supply increments only. Accredo offers you the opportunity to speak with pharmacists and clinicians about your condition, symptoms, drug side effects and more. You may contact Accredo at 800-803-2523 or visit ***accredo.com***.

Partial Fill Program

Specialty medications can have severe side effects, and some patients cannot tolerate the reactions and complications that may accompany taking them. Accredo manages a Partial Fill Program that limits the initial prescription to a 15-day supply for certain medications. This prevents waste in case the patient cannot tolerate the medication and, in those instances, saves the patient and the Plan money. Generally, for a partial fill, you will pay 50% of the Co-payment.

Prior Authorization Program for Specialty Medications

Any Covered Individual who is diagnosed with a serious disease or chronic condition may be prescribed a specialty medication. Most initial prescriptions for specialty drugs are reviewed by Accredo before the prescription is filled. This is called the Prior Authorization Program. Accredo communicates directly with your prescribing Physician during this process to ensure the medication is being dispensed for its intended use and in accordance with manufacturer recommendations. For example, with some medications, certain diagnostic and/or lab tests must be completed before the medications can be dispensed and Accredo confirms all requirements have been met. Specialty medications that are a part of a long-term Treatment Plan, generally extending more than a year, are subject to annual review.

For specialty medications, your Physician should call Accredo Specialty Pharmacy at 866-759-1557 or visit their website at ***accredo.com***. Service Representatives are available Monday–Friday from 7:00 a.m. to 10:00 p.m. and Saturday from 7:00 a.m. to 4:00 p.m. (CT).

Specialty Pharmacy Copay Assistance Program

The Plan uses a specialty pharmacy copay assistance program administered ***by SaveOnSP (the "SaveOnSP Program")***. Under the SaveOnSP Program, your copayments for Select Specialty Medications are not applied toward satisfying your Deductible or your out-of-pocket maximum. Additionally, the copayments that apply for the Select Specialty Medications vary from other specialty medications covered under the Plan. The SaveOnSP Specialty Drug List (available at ***saveonsp.com/crcc*** or by calling the Fund Office) lists the Select Specialty Medications subject to the SaveOnSP Program and their copayments. The specialty medications and copayment amounts listed on the SaveOnSP Specialty Drug List may be changed by SaveOnSP from time to time.

You should visit ***saveonsp.com/crcc*** to find the most up-to-date information on specialty medications subject to the Program and copayment amounts.

Member Assistance Program

The Member Assistance Program (MAP) provides twelve FREE short-term counseling sessions per issue for you and your covered Dependents through the Fund's Contracted Provider***, Lyra Health (Lyra)***. You also have access to online resources and information for personal and work-life issues.

If counseling is required beyond the twelve sessions available to each Covered Individual through the MAP, the Covered Individual can continue treatment under the comprehensive medical benefit.

Contact Lyra 24 hours a day, seven days a week at 877-368-0644. Visit ***carpenterbenefits.lyrahealth.com*** for more information on MAP.

For more details, refer to page 36 for the Active Plan Schedule of Benefits or page 44 for the Low Cost Medical Plan Schedule of Benefits.

Don't Stress Call Lyra

When you want answers or need help with work-life issues, contact MAP. You and your covered Dependents can receive twelve FREE and confidential counseling sessions per issue with a counselor or consultant who will talk with you about your struggles. A counselor or consultant listens objectively, guides you to solutions or refers you to another professional for help. Call Lyra at 877-368-0644. Support is available seven days a week, 24 hours a day.

Vision Benefits

Healthy eyes and sight are important to overall good health, so the Plan offers vision benefits to you and your covered Dependents through the Fund's Contracted Provider, ***VSP Vision Care (VSP)***. Highlights of your vision coverage include:

- No Deductible must be met before benefits are payable.
- When you use a VSP provider, the Plan covers the entire cost for an eye exam, and provides a generous allowance for frames.
- For an additional Co-payment, you can receive a contact lens fit and follow-up exam.
- Your coverage includes standard single, bifocal or trifocal lenses and safety lenses. Lens options (tints and coatings) are available for an additional Co-pay.
- If you use an Out-of-Network Provider, the Plan pays a benefit up to a limit for Covered Services, however, lens options (tints and coatings) are not covered.

For more details on covered vision services, the Active Plan *Schedule of Benefits*. Vision benefits are not available under the Low-Cost Medical Plan.

To locate a VSP provider call 800-877-7195 or visit their website at ***VSP.com***. Representatives are available Monday−Saturday from 6:30 a.m. to 10:00 p.m. and Sunday 10:00 a.m. to 7:00 p.m. (CT).

Dental Benefits

Good health goes hand in hand with good dental care, which is why the Plan includes comprehensive dental care. This includes preventive dental care, such as routine exams, cleanings, and X-rays; as well as basic dental care, major dental care and orthodontia for you and your covered Dependents. Dental benefits are provided through the Fund's Contracted Provider, ***Delta Dental of Illinois (Delta Dental)***. Dental benefits are not available to an apprentice except as described in the section titled Eligibility on page 8, nor are they available under the Low-Cost Medical Plan.

To locate a Delta Dental Network Provider, call 800-323-1743 or visit their website at deltadentalil.com. Service Representatives are available Monday –Thursday from 7:00 a.m. to 7:00 p.m. and Friday from 7:00 a.m. to 6:00 p.m. (CT).

There are two Networks offered by Delta Dental — the Delta Dental PPO and Premier Networks. This program has the largest Network of participating dental providers in the nation. Both Networks offer discounts and charge lower fees for their services. See the Schedule of Benefits on page 36.

Using a Delta Dental Network Provider means taking advantage of the Negotiated Rate and having lower out-of-pocket costs. To find a Network dental provider, contact Delta Dental at 800-323-1743 or visit their website at ***deltadentalil.com***.

The Active Plan *Schedule of Benefits* beginning on page 36 shows the annual Deductible, Covered Services and benefit maximum. Covered dental services include:

- **Preventive/diagnostic care** including:
  - Prophylaxis (cleaning);
  - Routine oral examination;
  - X-rays:
  - Bitewings;
  - Full mouth or panoramic; and
  - Cephalometric.
  - Topical fluoride applications for Dependent children (once in a 12-month period for Dependent children through age 18);
  - Sealants for Dependent children through age 14; and
  - Emergency palliative treatment.
- **Basic dental care** includes expenses incurred as a result of a dental disease or defect:
  - Fillings, including amalgam, synthetic porcelain or plastic restorations/fillings or gold restorative services when the teeth cannot be restored with another filling material;
  - Oral surgery for extraction of a tooth, including pre- and post-operative care;
  - Periodontic treatment;
  - Endodontic treatment;
  - Removal of cysts and tumors by a Dentist or Doctor of dentistry;
  - General anesthesia;
  - Consultations; and
  - Space maintainers.
- **Major dental care** includes:
  - Crowns, jackets and veneers, when a tooth cannot be restored with a filling material;
  - Prosthetics including bridges, partial and full dentures, space maintainers and orthodontic retainers; and

  - Dental implants, bone lengthening and related dental services.
- **Orthodontic care** includes the placement of orthodontic appliances. Charges for orthodontic care are not considered for payment until the orthodontic services are rendered.

Delta Dental "To Go"

With Delta Dental of Illinois' "To Go" program, Covered Individuals can carry over their unused Calendar Year maximum dollars from one year to the next. This means you don't have to leave unused dollars from your Calendar Year maximum behind. This program offers Covered Individuals more flexibility and can help you prepare for more extensive and costly dental treatment.

How It Works

The To Go program gives the Covered Individual the ability to carry over any qualified, unused portion of his Calendar Year maximum and apply it to his "To Go Bank," increasing his total dollars for dental treatment the following year. The following applies:

- A Covered Individual must have been covered under the Plan for the full benefit plan year (January 1st through December 31st) with coverage for major services.
- A Covered Individual must have submitted at least one Claim during the benefit plan year that would apply to his annual maximum with allowed dollar amounts that are greater than zero dollars. In other words, you must have had a dental service that applies to the annual maximum (preventive/diagnostic, basic or major) during the year to carry over any unused annual maximum.
- The carryover amount may not exceed the amount of the annual maximum. For example, if the annual maximum is $1,500, the total amount of To Go dollars available cannot exceed $1,500.
- A Covered Individual cannot take unused annual maximums with him upon termination of employment or the dental plan or apply the unused annual maximum to another dental plan.

Example					
Year 1		Year 2		Year 3	
Annual Maximum Benefit	$1,500	Annual Maximum	$1,500	Annual Maximum	$1,500
		To Go Bank Balance (Carried over from Year 1)	$1,000	**To Go Bank Balance** (Carried over from Year 2)	$1,500
		Total Available in Year 2 (Annual Max + To Go Bank carryover)	$2,500	**Total Available in Year 3** (Annual Max + To Go Bank carryover)	$3,000
Benefit Used in Year 1	$500	Benefit Used in Year 2	$900	Benefit Used in Year 3	$3,000
Unused Benefit	$1,000	**Unused Benefit**	$1,500	**Unused Benefit**	$0
To Go Benefit / Carryover (available for use in Year 2)	$1,000	**To Go Benefit / Carryover** (available for use in Year 3)	$1,500	**To Go Benefit / Carryover** (available for use in Year 4)	$0
The $500 that was used was subtracted from the annual maximum of $1,500 with $1,000 left unused. The Unused Benefit of $1,000 is carried over into the To Go Bank, increasing the total benefit available in Year 2.		**The total To Go Bank carryover amount cannot exceed the amount of the annual maximum ($1,500). Therefore, even though the Unused Benefit total is $1,600, only $1,500 of the unused benefit can be applied to the To Go Bank for carryover into Year 3.		**Because the benefit used exceeded the annual maximum by $1,500, the additional $1,500 was deducted from the To Go Bank. The total annual maximum of $1,500 was used so there is no carryover into Year 4.	

Short Term Disability Benefits

If you, the Employee, become ***Disabled*** and can't work due to a Non-Work-Related Illness or Injury, and you meet the criteria listed below, the Plan provides you with a weekly payment and contribution hours credit to the Health Fund. See the Active Plan *Schedule of Benefits* on page 36.

If you, the Employee, become Disabled and can't work due to a Work-Related Illness or Injury, and you meet the criteria listed below, the Plan will credit you with hours to the Health Fund. See the Active Plan *Schedule of Benefits* on page 36.

If you suffer a Work-Related Illness or Injury while working for a non-Contributing Employer and are unable to work, you are not eligible for Short Term Disability benefits (regardless of your eligibility status under the Plan), nor does the Plan credit you with hours to the Health Fund.

Eligibility for Short Term Disability Benefits

To be eligible for the Short Term Disability benefit you must meet all of the following requirements.

- You must be eligible for Active Plan benefits when you become Disabled;
- During the entire period of Disability, you must be under the active care of a licensed Physician;
- You may not be receiving a Pension Plan benefit; and
- A fully completed "Short Term Disability Claim Form" must be received by the Health Benefits Department.

Eligible Non-bargained Employees must also be actively employed by their Employer on the date they become disabled. Fund Office employees are initially eligible for Short Term Disability benefits following six consecutive months of employment.

Applying for Benefits

1. Contact the Health Benefits Department and request a Short Term Disability Claim Form, or you may go to ***carpenterbenefits.org*** and print the form.
2. Complete the Short Term Disability Claim Form in its entirety. Print clearly in blue or black ink and answer all questions. Be certain to have your attending Physician complete their part of the form. If the form is not legible, if a question is left unanswered, or if the form has not been signed, it will be returned to you for completion. The Short Term Disability Claim Form is not valid unless it is signed and dated by you and your attending Physician. Incomplete forms will be returned for completion and will result in a delay.
3. Mail, fax or email the completed Short Term Disability Claim Form to the Fund Office as follows:

Via Mail: Mid-America Carpenters Regional Council Health Fund
Attn: Short Term Disability Processing
12 E. Erie Street
Chicago, IL 60611

Via Fax: 312-951-2982

Via Email: *submit@macbenefits.org*

NOTE: *You may be required to submit to a physical examination by a Physician selected by the Fund to verify your Disability. The cost of the examination and any related medical expenses will be paid for by the Fund.*

When Benefits Begin

Weekly payments and credit of hours for a ***Non-Occupational Illness*** begin on the eighth calendar day after you first become Disabled; however, if you are continuously Disabled for four weeks or longer, benefits are payable beginning on the first full day of your Disability.

Weekly payments and credit of hours for a ***Non-Occupational Injury*** or Non-Occupational Accident begin from the first full day of a Physician-certified disability, regardless of the length of the Disability.

Occupational (Work-Related) Illnesses or Injuries are not eligible for the weekly benefit payment but may be eligible for credit of hours. Credit of hours for an Occupational Illness or Injury begins the first full day after the date your Physician certifies you as Disabled, regardless of the length of the Disability.

> The Plan will not pay medical benefits for an ***Occupational or Work-Related Illness or Injury***. Contact your Employer about making a claim for a Work-Related Illness or Injury.

About Your Benefits

Maximum Period: All periods for the same Physician-certified Illness or Injury, in aggregate, are limited to a 52-week maximum period (2,080 hours).

- **Non-Occupational Illness or Injury**: You will receive a weekly payment and credit of up to a maximum of 40 hours to the Health Plan for each calendar week of Disability during the period of time you remain Disabled.
- **Occupational Illness or Injury**: You will receive credit of up to a maximum of 40 hours to the Health Plan for each calendar week of Disability during the period of time you remain Disabled.

Continuous Disability: Disabilities occurring in any 12-month period of time are considered as one and the same claim if the Disability is for the same or related Illness or Injury.

Subsequent Disability: A new claim for a Short Term Disability benefit will begin only if:

- A subsequent Disability is due to an Illness or Injury unrelated to the previous Disability, and is separated by a return to work for at least 200 hours of Covered Employment with one or more Employers or
- If a subsequent Disability is caused by an Illness or Injury related to a previous Disability, you must provide proof that you have recovered and remained Non-Disabled for a period of at least 12 consecutive months before you will qualify for a new claim for a Short Term Disability.

For more information, or to request a Short Term Disability Claim Form, call the Health Benefits Department Monday– Friday from 8:00 a.m. to 4:30 p.m. (CT) at 312-787-9455. Or, to print the form yourself, visit the Fund's website at ***carpenterbenefits.org***.

> **Workers' Compensation Cases Only**: Occupational (Work-Related) Illnesses and Injuries are not eligible for the weekly benefit payment under the Short Term Disability benefit but may be eligible for credit of hours.

If you are filing for credit of hours through the Short Term Disability Benefit for an Occupational Illness or Injury, you must provide copies of all your Workers' Compensation lost wage Temporary Total Disability (TTD) check stubs. In lieu of TTD check stubs, you may also submit a ledger or benefit summary letter from

the Workers' Compensation carrier that details all lost wage benefits paid to you. Please include this information along with your completed Short Term Disability Claim Form.

When Short Term Disability Payments Are Issued

Short Term Disability payments and/or credit of hours are issued after the Health Benefits Department receives the fully completed Short Term Disability Claim Form, verifies the disability, and processes the claim. Weekly payments under the Short Term Disability benefit are generally issued on Thursdays.

Tax Withholding

The Plan will follow federal tax withholding rules when paying an Employee's weekly payment for Short Term Disability. Federal taxes are not automatically withheld. Please ask for a federal withholding form (W-4S) if you would like taxes to be automatically withheld, or you may download a form at ***carpenterbenefits.org***.

Maintaining Eligibility for Short Term Disability Benefits

In order to maintain eligibility for Short Term Disability benefits you must meet the following requirements:

- Each and every Calendar Quarter while on Short Term Disability, you must have at least 250 hours credited in the current Calendar Quarter (200 hours for apprentices), or 1,000 hours in the current Calendar Quarter (760 hours for apprentices) plus three preceding Calendar Quarters (as more fully described under the Eligibility section beginning on page 8). Hours credited to you during a Calendar Quarter include Contribution hours paid on your behalf by a Contributing Employer and/or hours credited to you as a Short Term Disability benefit.
- You and your attending Physician may be required to recertify your Disability in order to continue receiving Short Term Disability benefits. For purposes of determining your eligibility for credit of hours for an Occupational Illness or Injury, you may provide copies of all your Workers' Compensation lost wage Temporary Total Disability (TTD) check stubs or you may submit a ledger or benefit summary letter from the Workers' Compensation carrier, in lieu of a Physician recertification claim.

Who Is Not Eligible for Short Term Disability Benefits

- An Employee not eligible for benefits under the Active Plan.
- An Employee on Continuation Coverage under COBRA.
- An Employee covered under the Low Cost Medical Plan.
- The Employee's spouse or Dependent child.
- An Employee who is working for a non-Contributing Employer.

Short Term Disability Benefits Terminate at Retirement

You will not be eligible to receive more than six days of Short Term Disability benefits (weekly payments and/or credit of hours) in any month in which you receive a pension benefit.

Maternity Leave Benefits

If you, the Employee, are pregnant, and can't work due to your pregnancy, the Plan provides you with weekly payment and contribution hours credit to the Health Fund. See the Active Plan *Schedule of Benefits* on page 36.

Applying For Benefits

1. Contact the Health Benefits Department and request a Maternity Leave Claim Form, or you may go to ***carpenterbenefits.org*** and print the form.
2. Complete the Maternity Leave Claim Form in its entirety. Print clearly in blue or black ink and answer all questions. Be certain to have your attending Physician complete their part of the form. If the form is not legible, if a question is left unanswered, or if the form has not been signed, it will be returned to you for completion. The Maternity Leave Claim Form is not valid unless it is signed and dated by you and your attending Physician. Incomplete forms will be returned for completion and will result in a delay.
3. Mail, fax or email the completed Maternity Leave Claim Form to the Fund Office as follows:

   Via Mail: Mid-America Carpenters Regional Council Health Fund
   Attn: Short Term Disability Processing
   12 E. Erie Street
   Chicago, IL 60611

   Via Fax: 312-951-2982

   Via Email: *submit@macbenefits.org*

When Benefits Begin

Weekly payments and credit of hours can begin no earlier than 13 weeks before your expected due date (except for early delivery). You must fully complete the required claim form before benefits will be paid.

About Your Benefits

You will receive a weekly payment a credit of up to a maximum of 40 hours to the Health Fund for up to a maximum of 26 weeks per pregnancy. The Maternity Leave benefit is in lieu of the Short Term Disability benefit. This means you are not eligible for Short Term Disability benefits for the same pregnancy.

When Maternity Leave Payments Are Issued

Maternity Leave payments and/or credit of hours are issued after the Health Benefits Department receives of the fully completed Maternity Leave Claim Form, verifies the information, and processes the claim. Weekly payments under the Maternity Leave benefit are generally issued on Thursdays.

Tax Withholding

The Plan will follow federal tax withholding rules when paying weekly payment for Maternity Leave. Federal taxes are not automatically withheld. Please ask for a federal withholding form (W-4S) if you would like taxes to be automatically withheld, or you may download a form at ***carpenterbenefits.org***.

Who Is Not Eligible for Maternity Leave Benefits

- Employees enrolled in the Low Cost Medical Plan or Continuation Coverage under COBRA;
- Non-bargained Employees;
- Dependents

Life and Accidental Death and Dismemberment Insurance Benefits

Life Insurance Benefits for You

If you are eligible for the benefits under the Active Plan or the Low Cost Medical Plan, you are also covered under the Life Insurance benefit. For more details, see the Active Plan Schedule of Benefits on page 36 or page 44 for the Low Cost Medical Plan *Schedule of Benefits*. If there is a discrepancy between this Summary Plan Description and the Life Insurance policy, the terms of the Life Insurance policy will govern.

The Active Plan provides an optional accelerated death benefit, which will pay you a partial benefit if you are diagnosed with a terminal illness. Certain restrictions apply. The optional accelerated death benefit is not provided under the Low Cost Medical Plan.

If you become totally and permanently disabled before age 60, you may apply for continuation of your Life Insurance benefit. If approved, your coverage under the Life Insurance benefit will continue at no cost to you until the first of the following to occur:

- You are no longer totally and permanently disabled;
- You turn age 65;
- You fail to provide the required proof of disability;
- You fail to be examined by the Insurance Company's physician (if required).

Proof of Disability must be filed with the Health Benefits Department at the Fund Office within 12 months after loss of eligibility.

Subsequent proof of Disability will be required on a regular basis from the Life Insurance Company. In the event the group policy is discontinued, your Life Insurance Benefit will terminate.

To designate a beneficiary: You may designate one or more beneficiaries or make changes to your previous beneficiary designation at any time by completing an Enrollment and Beneficiary Designation Form available from the Fund's website at ***carpenterbenefits.org***. or call the Health Benefits Department at 312-787-9455 to request that a form be mailed to you.

Your beneficiary designation does not become effective until a properly completed Beneficiary Designation Form is received by the Health Benefits Department. If the Fund Office does not have a Beneficiary Designation Form on file for you, payment will be made consistent with the insurance policy rules. As of January 1, 2026, payment will be made to your surviving spouse. If no spouse survives you, payment will be made in equal shares to your biological and adopted children who survive your death. If no children survive you, payment will be made to your living parents equally, or to the surviving parent. If neither parent survives you, payment will be made in equal shares to your brothers and sisters who survive you. If no siblings survive you, payment will be made to the participant's estate.

In the event that your marriage is terminated by divorce, the designation of your Spouse as beneficiary (but not other beneficiary designations) becomes automatically void. If you wish to maintain your former Spouse as your beneficiary after your marriage is legally terminated by divorce, you must complete a new Beneficiary Designation Form listing your former Spouse as beneficiary following the legal termination of your marriage or divorce.

Life Insurance Benefits for Your Dependents

The Plan provides coverage under the Life Insurance benefit for your Dependents who are eligible under the Active Plan or the Low Cost Medical Plan. See the *Schedule of Benefits* for details.

Converting Your Life Insurance Coverage

If your eligibility under the Active Plan terminates, you can apply to convert your and your Dependents' Life Insurance coverage under the Life Insurance benefit to an individual life insurance policy, to the extent permitted by the Insurance Company. Contact the Health Benefits Department for a conversion application. You must complete the application and file it with the Insurance Company within 31 days after your eligibility terminates.

Accidental Death and Dismemberment Benefits

(Not Applicable to the Low Cost Medical Plan or Continuation Coverage under COBRA)

If you, the Employee, are eligible for the Active Plan, you are automatically eligible for the Plan's Accidental Death and Dismemberment (AD&D) Insurance benefit. The Plan will provide payment if you, while you are insured, lose eyesight, limb(s) or life due to an Injury or Accident (even if sustained while on the job). Benefits are paid to you except for a loss of life which is paid to your beneficiary. If there is a discrepancy between this Summary Plan Description and the insured policy for AD&D, the terms of the AD&D insurance policy will govern. AD&D benefits are not available for Dependents.

Filing a claim: On your behalf, the Health Benefits Department will submit your Claim to the AD&D Insurance Company. If the AD&D Insurance Company determines that a benefit is payable, they will typically send payment within 30 days of the date the Claim is filed. In case of a death Claim, a certified final death certificate (U.S. Standard Certificate of Death) will be required in order to apply for the benefit. Medical records will be required for other losses.

To initiate a claim for Life or AD&D Insurance benefits, contact the Health Benefits Department at 312-787-9455.

Schedule of Benefits–For the Active Plan of Benefits

The schedule on the following pages highlights key features of the Active Plan of Benefits for Covered Individuals.

- The amounts charged for Covered Medical Expenses provided by Network Providers are subject to the PPO allowed contractual amounts. A Covered Individual will not be balance billed for amounts over the allowed contractual amount.
- The amounts charged for Covered Medical Expenses provided by Out-of-Network Providers are subject to the Reasonable and Customary Allowance (R&C Allowance) except as required by law for Protected Services. R&C Allowances are determined by the Trustees (or their designee) in their sole discretion and are amended from time to time. Out-of-Network charges are paid at 285% of the Medicare Physician Fee Schedule, National Payment Amount Schedule. A Covered Individual is responsible to pay for amounts over the R&C Allowance.

Comprehensive Medical Benefits		
	PPO Provider	Out-of-Network Provider
Coinsurance	80% paid by Plan	60% paid by Plan
	Protected Services are payable at the PPO Provider rate.	
Deductible per Calendar Year	$300 per Covered Individual $900 per family	$600 per Covered Individual $1,800 per family
Out-of-Pocket Maximum per Calendar Year	$2,300 per Covered Individual $6,900 per family (includes Calendar Year Deductible)	$6,000 per Covered Individual $18,000 per family (does not include Calendar Year Deductible)
	After a Covered Individual satisfies the Deductible and Out-of-Pocket Maximum, the Plan will pay 100% of most eligible Covered Services for the remainder of the Calendar Year. PPO and Non-PPO Deductibles and Out-of-Pocket Maximums are separate and cannot be combined. Charges for Protected Services will count toward the PPO Deductible and Out-of-Pocket Maximum.	

Medical Benefits Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)		
	BCBS PPO Provider	Out-of-Network Provider
Acupuncture Care	See Chiropractic, Acupuncture and Naprapathic Care, page 37	
Ambulance Service	80% paid by Plan subject to the PPO Deductible	
Anesthesia or Sedation	80% paid by Plan	60% paid by Plan
Behavioral Health Care including outpatient therapy, partial hospitalization and hospital outpatient diagnostic tests. See Hospital Care and Residential Treatment Facilities for inpatient care.	80% paid by Plan	60% paid by Plan
Breast-Feeding Support and Equipment to the extent required under the Affordable Care Act • Lactation support and counseling • Breast pump rental up to the purchase price and initial supplies (tubing and shields). Limited to one non-retail purchase per pregnancy • Hospital-grade breast pump must be Medically Necessary	100% paid by Plan Calendar Year Deductible does not apply	No coverage

Medical Benefits Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)			
	BCBS PPO Provider		Out-of-Network Provider
Chiropractic, Acupuncture and Naprapathic Care (Combined Benefit)	80% paid by Plan		60% paid by Plan
	Maximum visit limit per Employee: 50 visits per Calendar Year Maximum visit limit per spouse: 30 visits per Calendar Year Maximum visit limit per Dependent child age 12 and older: 15 visits per Calendar Year No coverage for Dependent children under age 12		
Contraceptives, including related ***Office Visits***, contraceptive support and counseling, to the extent required under the Affordable Care Act for FDA-approved methods for females with reproductive capacity	100% paid by the Plan Calendar Year Deductible does not apply		No coverage
Dental Services for a Non- Occupational Injury to teeth	80% paid by Plan		60% paid by Plan
	Annual Dental benefit must be exhausted first		
Diagnostic Imaging Benefit – MRI, CAT/CT and PET Scans	Absolute Solutions Network	BCBS PPO Provider	Out-of-Network Provider
	100% paid by Plan (Calendar Year Deductible does not apply	80% paid by Plan	60% paid by Plan
	BCBS PPO Provider		Out-of-Network Provider
Diagnostic X-Rays and Lab Tests	80% paid by Plan		60% paid by Plan
Durable Medical Equipment	80% paid by Plan		60% paid by Plan
Emergency Services • Facility fee • Physician fees	 80% paid by Plan 80% paid by Plan		 80% paid by Plan 80% paid by Plan
Emergency Room Co-payment	$250 per Emergency Room visit Waived if admitted to the Hospital as an inpatient within 72 hours or held in the observation unit for more than 24 hours Emergency Room Co-payment no longer applicable after Covered Individual meets the applicable Calendar Year Out-of-Pocket Maximum		
Extended Care/Skilled Nursing Facility	80% paid by Plan		60% paid by Plan
	Maximum of 120 days per convalescent period		
Gender Affirming Care	80% paid by Plan		60% paid by Plan
Genetic Testing Benefit			
• Genetic testing to the extent required under the Affordable Care Act	100% paid by Plan Calendar Year Deductible does not apply		60% paid by Plan Subject to Calendar Year Deductible, Out-of-Pocket Maximum and the combined annual maximum benefit of $7,500
• Diagnostic genetic testing	80% paid by Plan		60% paid by Plan
	Subject to Calendar Year Deductible, Out-of-Pocket Maximum and the combined annual maximum benefit of $7,500		
• Non-diagnostic genetic testing	No coverage		No coverage
Hearing Benefit			
• Hearing evaluation/exam for a newborn (ages 0-to 31 days) as required under the Affordable Care Act	100% paid by Plan Calendar Year Deductible does not apply		80% paid by Plan Calendar Year Deductible does not apply
• Hearing evaluation/exam	Paid at 100% per Covered Individual once every two consecutive Calendar Years		No coverage

• Hearing aid instrument	Preferred Contracted Provider: EPIC Hearing Service (Hearing Aid Only)	BCBS PPO Provider	Out-of-Network Provider
– Dependent children through age 18	Paid at 100% up to $5,000 maximum per Covered Individual once every three consecutive Calendar Years. Calendar Year Deductible does not apply		
– Participant, spouse and Dependent children age 19 and older	Paid at 100% up to $5,000 maximum per Covered Individual once every five consecutive Calendar Years. Calendar Year Deductible does not apply		
	BCBS PPO Provider	Out-of-Network Provider	
Home Health Care	80% paid by Plan	60% paid by Plan	
	Maximum of 120 visits per year		
Hospice Care	80% paid by Plan	60% paid by Plan	
	Lifetime maximum of 180 days per Covered Individual		
Hospital Care	80% paid by Plan	60% paid by Plan	
	Confinement maximum: 180 days per Calendar Year for inpatient care, additional days may be covered if Medically Necessary		
Infertility Services including Hospital, Physician, prescription drugs and treatments, except diagnostic genetic testing. See Genetic Testing on page 37 for coverage	80% paid by Plan	60% paid by Plan	
	Combined lifetime maximum of $60,000 for services provided to the Employee and spouse		
Infusion Therapy for the administration of an intravenous prescription drug	80% paid by Plan	60% paid by Plan	
Member Assistance Program	See page 39		
Naprapathic Care	See Chiropractic, Acupuncture and Naprapathic Care, page 37		
Nutritional Counseling to the extent required under the Affordable Care Act	100% paid by Plan Calendar Year Deductible does not apply	No coverage	
Oral and Maxillofacial Surgery	80% paid by Plan	60% paid by Plan	
Organ Transplant	80% paid by Plan	60% paid by Plan	
Physician Services	80% paid by Plan	60% paid by Plan	
Pregnancy Care	80% paid by Plan, except Services covered under the Affordable Care Act are paid at 100% by the Plan and the Calendar Year Deductible does not apply	60% paid by Plan	
Prosthetics	80% paid by Plan	60% paid by Plan	
• Artificial limbs and eyes • Wigs and hairpieces for hair loss as a result of treatment for a cancer diagnosis	100% paid by Plan, subject to a $500 lifetime maximum Calendar Year Deductible does not apply		
Reconstructive Breast Surgery	80% paid by Plan	60% paid by Plan	
Residential Treatment Facilities	80% paid by Plan	60% paid by Plan	
	Confinement maximum: 180 days per Calendar Year for inpatient care, additional days may be covered if Medically Necessary		
Sterilization • Females to the extent required under the Affordable Care Act	100% paid by Plan Calendar Year Deductible does not apply	No coverage	
• Males	80% paid by Plan	No coverage	
• Sterilization reversals (female/male)	No coverage	No coverage	

	BCBS PPO Provider	Out-of-Network Provider
Substance Use Disorder Treatment including outpatient therapy, partial hospitalization and hospital outpatient diagnostic tests. See Hospital Care and Residential Treatment Facilities for inpatient care.	80% paid by Plan	60% paid by Plan
Surgi-Center Facility • Hospital affiliated • No hospital affiliation	80% paid by Plan 80% paid by Plan	60% paid by Plan No coverage
Surgical Assistant or Assistant Surgeon	80% paid by Plan	60% paid by Plan, limited to 20% of surgical procedure's R&C Allowance
Surgical Consultations	80% paid by Plan	60% paid by Plan
Temporomandibular Joint Care (TMJ) • Physician and therapy services	80% paid by Plan	60% paid by Plan
• Appliances, and their adjustments, for TMJ and bruxism (occlusal)	80% paid by Plan once every three consecutive years Maximum of two appliances per lifetime	
Therapy Services	80% paid by Plan	60% paid by Plan
Physical and Speech Outpatient Therapy	Maximum 50 visits per Calendar Year	
(For additional benefits beyond the 50-visit maximum limit, see page 61)	60% paid by Plan	40% paid by Plan
Occupational Outpatient Therapy	80% paid by Plan	60% paid by Plan
	Maximum 50 visits per Calendar Year	
(For additional benefits beyond the 50-visit maximum limit, see page 61)	60% paid by Plan	40% paid by Plan
Physical, Occupational and Speech Outpatient Therapy for Developmental Disabilities (Habilitative or to teach; for Covered Individuals through age 18)	80% paid by Plan	60% paid by Plan
Urgent/Immediate Care Facilities and Retail Clinics	80% paid by Plan	60% paid by Plan
Vision Surgery (excluding Cosmetic or refractive corrections)	80% paid by Plan	60% paid by Plan
• Premium Lens replacements in conjunction with cataract surgery	$1,000 maximum per lens (maximum two lenses per lifetime)	
Wellness and Preventive Care to the extent required under the Affordable Care Act, including routine screenings, immunizations and other services (For a list of services, see ***healthcare.gov***)	100% paid by Plan Calendar Year Deductible does not apply	No coverage
HEALTH CENTER BENEFITS For Eligible Covered Individuals Only		
Health Center Services	100% paid by Plan. Calendar Year Deductible does not apply	
MEMBER ASSISTANCE PROGRAM Contracted Network Provider: Lyra Health		
	Lyra, In-Network Provider	Out-of-Network Provider
Member Assistance Program	100% paid by Plan for 12 short-term counseling sessions per Calendar Year	*No Coverage*

VISION CARE BENEFITS Contracted Network Provider: VSP		
	VSP In-Network Provider (Participant's Cost)	**Out-of-Network Provider** (Maximum Amount Plan Pays)
Frequency • Exam • Lenses or contacts • Frames	Once per Calendar Year	
Eye Exam Co-payment (with dilation, if necessary)	$0 Co-pay	Plan pays up to $45
Frames Allowance Up to $200 or $220 for VSP featured frame brands	$0 Co-pay	Plan pays up to $70
Standard Plastic or Safety Lenses Co-payment • Single vision	$0 Co-pay	Plan pays up to $30
• Bifocal	$0 Co-pay	Plan pays up to $50
• Trifocal	$0 Co-pay	Plan pays up to $65
• Standard progressive lens	$65 Co-pay	Plan pays up to $50
• Premium progressive lens	$95-$105 Co-pay	Plan pays up to $50
Custom progressive lens	$150-$175 Co-pay	Plan pays up to $50
Contacts (in lieu of Glasses) • $150 allowance	$0 Co-pay	Plan pays up to $150
• Contact lens exam (fitting and evaluation)	$40 Co-pay	
Safety Glasses (Employees only) • Safety Frame from the ProTec Eyewear Collection and • Lenses – prescription single vision, lined bifocal and lined trifocal. Polycarbonate and progressives covered in full	$10 Co-pay	No coverage

DENTAL BENEFITS Contracted Network Provider: Delta Dental of Illinois Dental benefits are not available to an apprentice except as described in the section titled Eligibility, on page 8.			
	Delta Dental PPO	**Delta Dental Premier**	**Out-of-Network**
Annual Maximum	$2,500		
Annual Deductible (applies only to Basic and Major Care)	$50/person $100/family		
Balance Billing (The difference between the Dentist's actual charge and the amount allowed by Delta Dental.)	Does not apply	Does not apply	Applies. A Covered Individual is responsible for charges exceeding Delta Dental's maximum plan allowance
Preventive/Diagnostic Care (1) Covered Individual through age 18	Paid at 100% of Delta Dental's PPO reduced schedule, not subject to the annual Deductible or annual maximum	Paid at 100% of Delta Dental's maximum plan allowance, not subject to the annual Deductible or annual maximum	Paid at 100% of Delta Dental's maximum plan allowance, not subject to the annual Deductible or to the annual maximum
Covered Individual – ages 19 and older	Paid at 100% of Delta Dental's PPO reduced schedule, not subject to the annual Deductible, but subject to the annual maximum	Paid at 100% of Delta Dental's maximum plan allowance, not subject to the annual Deductible, but subject to the annual maximum	Paid at 100% of Delta Dental's maximum plan allowance, not subject to the annual Deductible, but subject to the annual maximum

	Delta Dental PPO	Delta Dental Premier	Out-of-Network
Basic Care (2) **(all ages)**	Paid at 80% of Delta Dental's PPO reduced schedule, subject to the annual Deductible and the annual maximum	Paid at 80% of Delta Dental's maximum plan allowance, subject to the annual Deductible and the annual maximum	Paid at 80% of Delta Dental's maximum plan allowance, subject to the annual Deductible and the annual maximum
Major Care (3) **(all ages)**	Paid at 80% of Delta Dental's PPO reduced schedule, subject to the annual Deductible and the annual maximum	Paid at 80% of Delta Dental's maximum plan allowance, subject to the annual Deductible and the annual maximum	Paid at 80% of Delta Dental's maximum plan allowance, subject to the annual Deductible and the annual maximum
Orthodontia Dependent children through age 18	When services are rendered by a Delta Dental provider, the first $5,000 in orthodontia charges are paid at 80%. If you met the $2,000 lifetime maximum benefit that was in effect prior to 07-01-2011, all subsequent orthodontia payments will be paid at 25%.		Paid at 80% of the dentist's usual fee subject to a lifetime maximum of $2,000
Adults −ages 19 and older	Paid at 80% of Delta Dental's PPO reduced fee schedule, subject to a lifetime maximum of $2,000	Paid at 80% of the dentist's usual fee subject to a lifetime maximum of $2,000	Paid at 50% of the dentist's fee subject to a lifetime maximum of $2,000

(1) **Preventive/Diagnostic Care** includes:

✓ Oral evaluations (two in 12-month period) ✓ Prophylaxis/Cleaning (two in a 12-month period) ✓ X-rays (bitewings two in a 12-month period; full mouth or panoramic once in 36-month period; cephalometric once in a 24-month period)	✓ Fluoride treatment (once in a 12-month period for Dependent children through age 18) ✓ Palliative treatment ✓ Sealants (once per lifetime on 1st and 2nd molars only, for Dependent children through age 14)

(2) **Basic Care** includes:

✓ Fillings ✓ Oral Surgery ✓ General Anesthesia ✓ Periodontics	✓ Endodontics ✓ Consultations ✓ Removal of cysts and tumors in the mouth ✓ Space Maintainers (5-year interval for dependent children up to age 13)

(3) **Major Care** (services are covered once in a 5-year period, to the day) includes:

✓ Crowns, Jackets and Case Restoration ✓ Fixed and Removable Bridges ✓ Partial and Full Dentures	✓ Veneers (Permanent Teeth Only) ✓ Implants and related services

Note: All frequency limitations listed above are to the day

PRESCRIPTION BENEFITS

Contracted Network Provider: Express Scripts, Inc. and Accredo Specialty Pharmacy

Prescription drug benefits are not available to an apprentice except as described in the section titled Eligibility, on page 8.

	Express Scripts Retail Pharmacy Network (Lesser of 100 units or a 30-day supply)	Express Scripts Mail Order Program (Up to a 90-day supply through mail order)	Accredo Specialty Pharmacy (For specialty drugs)
Out-of-Pocket Maximum per Calendar Year	$2,000 per Covered Individual $4,000 per family		
Generic Co-payment	$5	$12.50	Does not apply
Single-Source Brand Co-payment (A generic is not available)	20% $10 minimum Co-payment per drug with a $100 max	$12.50	Does not apply

	Express Scripts Retail Pharmacy Network (Lesser of 100 units or a 30-day supply)	Express Scripts Mail Order Program (Up to a 90-day supply through mail order)	Accredo Specialty Pharmacy (For specialty drugs)
Multi-Source Brand Co-payment (A generic is available)	35% $20 minimum Co-payment	20% $25 minimum Co-payment per drug with a $250 maximum	Does not apply
Preventive Care Drugs • Including FDA approved contraceptives • Excluding Brand drugs	$0	35% $50 minimum Co-payment	Does not apply
Omnipod Insulin Pump	20% $10 minimum Co-payment per pump with a $100 maximum	20% $25 minimum Co-payment per pump with a $100 maximum	Does not apply
Specialty Medication Co-payment (Used to treat complex conditions such as cancer, hemophilia, immune deficiency, rheumatoid arthritis, etc. and require a higher level of care)	Does not apply		$20 minimum Co-payment per drug with a $100 maximum
Select Specialty Medications	Does not apply		See page 25

SHORT TERM DISABILITY BENEFITS (For Eligible Employees Only)	
Non-Occupational Short Term Disability Benefits (Not Work Related)	Weekly benefits include a payment up to $550 and credit of up to 40 Health Fund hours for a Disability from the date certified by a Physician. Not to exceed a maximum of 52 weeks.
Occupational Short Term Disability Benefits (Work-Related)	Weekly benefits include credit up to 40 Health Fund hours for a Disability from the date certified by a Physician. Not to exceed a maximum of 52 weeks.
Maternity Leave Benefits	Weekly benefits include a payment of $800 and credit of up to 40 Health Fund hours for a pregnancy or pregnancy-related condition certified by a Physician beginning no earlier than 13 weeks before your expected due date (unless early delivery). Not to exceed a maximum of 26 weeks.

LIFE INSURANCE BENEFITS Contracted Provider: MetLife			
	Eligible Participant	**Spouse**	**Child**
Policy Amount	$50,000	$2,500	$2,000

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFITS (For Eligible Employees Only) Contracted Provider: MetLife			
Type of Loss	**Benefit Amount**	**Type of Loss**	**Benefit Amount**
Life	$50,000	One arm or one leg	$37,500
One hand and one foot	$50,000	Paralysis of both legs	$37,500
One foot and sight of one eye	$50,000	Sight of one eye	$25,000
One hand and sight of one eye	$50,000	One foot	$25,000
Sight of both eyes	$50,000	One hand	$25,000
Speech and hearing in both ears	$50,000	Speech or hearing	$25,000
Type of Loss	**Benefit Amount**	**Type of Loss**	**Benefit Amount**
Both feet	$50,000	Paralysis of arm and leg on either side of the body	$25,000
Both hands	$50,000	Thumb and index finger of same hand	$12,500
Paralysis of both arms and both legs	$50,000	Paralysis of one arm or one leg	$12,500
Brain Damage	$50,000	Third-degree burn	A percentage of $50,000 equal to the percentage of body surface suffering the third-degree burns
Coma	$500/day beginning on the 7th day not to exceed 60 months		

Schedule of Benefits for the Low Cost Medical Plan of Benefits

The schedule on the following pages highlights key features of the Low Cost Medical Plan of Benefits for Covered Individuals.

- The amounts charged for Covered Medical Expenses provided by Network Providers are subject to the PPO allowed contractual amounts. A Covered Individual will not be balance billed for amounts over the allowed contractual amount.
- The amounts charged for Covered Medical Expenses provided by Out-of-Network Providers are subject to the Reasonable and Customary Allowance (R&C Allowance), except as required by law for Protected Services. R&C Allowances are determined by the Trustees (or their designee) in their sole discretion and are amended from time to time. Out-of-Network charges are paid at 285% of the Medicare Physician Fee Schedule, National Payment Amount Schedule. A Covered Individual is responsible to pay for amounts over the R&C Allowance.

Comprehensive Medical Benefits		
	PPO Provider	Out-of-Network Provider
Coinsurance	70% paid by Plan	50% paid by Plan
	Protected Services are payable at the PPO Provider rate.	
Deductible per Calendar Year	$600 per Covered Individual / $1,800 per family	
Out-of-Pocket Maximum per Calendar Year	$4,600 per Covered Individual / $9,200 per family	
	After a Covered Individual satisfies the Deductible and Out-of-Pocket Maximum, the Plan will pay 100% of most eligible Covered Services for the remainder of the Calendar Year. PPO and Non-PPO Deductibles and Out-of-Pocket Maximums are separate and cannot be combined. Charges for Protected Services will count toward the PPO Deductible and Out-of-Pocket Maximum.	

Medical Benefits Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)		
	BCBS PPO Provider	Out-of-Network Provider
Acupuncture Care	See Chiropractic, Acupuncture and Naprapathic Care, page 45	
Ambulance Service	70% paid by Plan subject to the PPO Deductible	
Anesthesia or Sedation	70% paid by Plan	50% paid by Plan
Behavioral Health Care including outpatient therapy, partial hospitalization and hospital outpatient diagnostic tests. See Hospital Care and Residential Treatment Facilities for inpatient care.	70% paid by Plan	50% paid by Plan
Breast-Feeding Support and Equipment to the extent required under the Affordable Care Act • Lactation support and counseling • Breast pump rental up to the purchase price and initial supplies (tubing and shields). Limited to one non-retail purchase per pregnancy • Hospital-grade breast pump must be Medically Necessary	100% paid by Plan, Calendar Year Deductible, does not apply	No coverage

Medical Benefits Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)		
	BCBS PPO Provider	**Out-of-Network Provider**
Chiropractic, Acupuncture and Naprapathic Care (Combined Benefit)	70% paid by Plan	50% paid by Plan
	Maximum visit limit per Employee: 50 visits per Calendar Year Maximum visit limit per spouse: 30 visits per Calendar Year No coverage for Dependent children	
Contraceptives, including related ***Office Visits***, contraceptive support and counseling, to the extent required under the Affordable Care Act for FDA-approved methods for females with reproductive capacity	100% paid by the Plan Calendar Year Deductible does not apply	No coverage
Dental Services for a Non- Occupational Injury to teeth	No Coverage	
Diagnostic Imaging Benefit – MRI, CAT/CT and PET Scans	70% paid by Plan	50% paid by Plan
Diagnostic X-Rays and Lab Tests	70% paid by Plan	50% paid by Plan
Durable Medical Equipment	70% paid by Plan	70% paid by Plan
Emergency Services • Facility fee • Physician fees	70% paid by Plan	70% paid by Plan
Emergency Room Co-payment	$300 per Emergency Room visit Waived if admitted to the Hospital as an inpatient within 72 hours or held in the observation unit for more than 24 hours Emergency Room Co-payment no longer applicable after Covered Individual meets the Calendar Year Out-of-Pocket Maximum	
Extended Care/Skilled Nursing Facility	70% paid by Plan	50% paid by Plan
	Maximum of 120 days per convalescent period	
Gender Affirming Care	70% paid by Plan	50% paid by Plan
Genetic Testing Benefit		
• Genetic testing to the extent required under the Affordable Care Act	100% paid by Plan Calendar Year, Deductible does not apply	50% paid by Plan Subject to Calendar Year Deductible, Out-of-Pocket Maximum and the combined annual maximum benefit of $7,500
	Subject to Out-of-Pocket Maximum and the combined annual maximum benefit of $7,500	
• Diagnostic genetic testing	70% paid by Plan	50% paid by Plan
	Subject to Calendar Year Deductible, Out-of-Pocket Maximum and the combined annual maximum benefit of $7,500	
• Non-diagnostic genetic testing	No coverage	No coverage
Hearing Benefit	No coverage, except as required by the Affordable Care Act under the Wellness and Preventive Care benefit	
Home Health Care	70% paid by Plan	50% paid by Plan
	Maximum of 120 visits per year	
Hospice Care	70% paid by Plan	50% paid by Plan
	Lifetime maximum of 180 days per Covered Individual	
Hospital Care	70% paid by Plan	50% paid by Plan
	Confinement maximum: 180 days per Calendar Year for inpatient care, additional days may be covered if Medically Necessary	

	BCBS PPO Provider	Out-of-Network Provider
Infertility Services including Hospital, Physician, prescription drugs and treatments, except diagnostic genetic testing. See Genetic Testing on page 45 for coverage	70% paid by Plan	50% paid by Plan
	Combined lifetime maximum of $60,000 for services provided to the Employee and spouse	
Infusion Therapy for the administration of an intravenous prescription drug	70% paid by Plan	50% paid by Plan
Member Assistance Program	See page 47	
Naprapathic Care	See Chiropractic, Acupuncture and Naprapathic Care, page 45	
Nutritional Counseling to the extent required under the Affordable Care Act	100% paid by Plan Calendar Year Deductible does not apply	No coverage
Oral and Maxillofacial Surgery	70% paid by Plan	50% paid by Plan
Organ Transplant	70% paid by Plan	50% paid by Plan
Physician Services	70% paid by Plan	50% paid by Plan
Pregnancy Care	70% paid by Plan, except Services covered under the Affordable Care Act are paid at 100% by the Plan and the Calendar Year Deductible does not apply	50% paid by Plan
Prosthetics • Artificial limbs and eyes • Wigs and hairpieces for hair loss as a result of treatment for a cancer diagnosis	70% paid by Plan	50% paid by Plan
	No Coverage	
Reconstructive Breast Surgery	70% paid by Plan	50% paid by Plan
Residential Treatment Facilities	70% paid by Plan	50% paid by Plan
	Confinement maximum: 180 days per Calendar Year for inpatient care, additional days may be covered if Medically Necessary	
Sterilization • Females to the extent required under the Affordable Care Act	100% paid by Plan Calendar Year Deductible does not apply	No coverage
• Males	70% paid by Plan	No coverage
• Sterilization reversals (female/male)	No coverage	No coverage
Substance Use Disorder Treatment including outpatient therapy, partial hospitalization and hospital outpatient diagnostic tests. See Hospital Care and Residential Treatment Facilities for inpatient care.	70% paid by Plan	50% paid by Plan
Surgi-Center Facility • Hospital affiliated • No hospital affiliation	70% paid by Plan 70% paid by Plan	50% paid by Plan No coverage
Surgical Assistant or Assistant Surgeon	70% paid by Plan	50% paid by Plan, limited to 20% of surgical procedure's R&C Allowance
Surgical Consultations	70% paid by Plan	50% paid by Plan
Temporomandibular Joint Care (TMJ) • Physician and therapy services	70% paid by Plan	50% paid by Plan
• Appliances, and their adjustments, for TMJ and bruxism (occlusal)	70% paid by Plan once every three consecutive years Maximum of two appliances per lifetime	

	BCBS PPO Provider	Out-of-Network Provider
Therapy Services		
Physical and Speech Outpatient Therapy	70% paid by Plan	50% paid by Plan
	Maximum 50 visits per Calendar Year	
For additional benefits beyond the 50, visit maximum limit, see page 61)	50% paid by Plan	30% paid by Plan
Occupational Outpatient Therapy	70% paid by Plan	50% paid by Plan
	Maximum 50 visits per Calendar Year	
Additional benefits beyond the 50 visit maximum limit, see page 61)	50% paid by Plan	30% paid by Plan
Physical, Occupational and Speech Outpatient Therapy for Developmental Disabilities (Habilitative or to teach; for Covered Individuals through age 18)	70% paid by Plan	50% paid by Plan
Urgent/Immediate Care Facilities and Retail Clinics	70% paid by Plan	50% paid by Plan
Vision Surgery (excluding Cosmetic or refractive corrections)	70% paid by Plan	50% paid by Plan
Wellness and Preventive Care to the extent required under the Affordable Care Act, including routine screenings, immunizations and other services (For a list of services, see ***healthcare.gov***)	100% paid by Plan Calendar Year Deductible does not apply	No coverage

HEALTH CENTER BENEFITS

For Eligible Covered Individuals Only

Health Center Services	100% paid by Plan. Calendar Year Deductible does not apply

MEMBER ASSISTANCE PROGRAM

Contracted Network Provider: Lyra Health

	Lyra, In-Network Provider	Out-of-Network Provider
Member Assistance Program	100% paid by Plan for 12 short-term counseling sessions per Calendar Year	No Coverage

PRESCRIPTION BENEFITS

Contracted Network Provider: Express Scripts, Inc. and Accredo Specialty Pharmacy

Prescription drug benefits are not available to an apprentice except as described in the section titled Eligibility, on page 8.

	Express Scripts Retail Pharmacy Network (Lesser of 100 units or a 30-day supply)	Express Scripts Mail Order Program (Up to a 90-day supply through mail order)	Accredo Specialty Pharmacy (For specialty drugs)
Out-of-Pocket Maximum per Calendar Year	$2,000 per Covered Individual $4,000 per family		
Generic Co-payment	70% paid by Plan		Does not apply
Single-Source Brand Co-payment (A generic is not available)	70% paid by Plan		Does not apply
Multi-Source Brand Co-payment (A generic is available)	70% paid by Plan		Does not apply
Preventive Care Drugs • Including FDA approved contraceptives • Excluding Brand drugs	100% paid by Plan		Does not apply

	Express Scripts Retail Pharmacy Network (Lesser of 100 units or a 30-day supply)	Express Scripts Mail Order Program (Up to a 90-day supply through mail order)	Accredo Specialty Pharmacy (For specialty drugs)
Omnipod Insulin Pump	70% paid by Plan		Does not apply
Specialty Medication Co-payment (Used to treat complex conditions such as cancer, hemophilia, immune deficiency, rheumatoid arthritis, etc. and require a higher level of care)	Does not apply		70% paid by Plan
Select Specialty Medications	Does not apply		See page 25

LIFE INSURANCE BENEFITS Contracted Provider: MetLife			
	Eligible Participant	**Spouse**	**Child**
Policy Amount	$5,000	$1,000	$1,000

EXCLUDED BENEFITS	
Vision Benefits	No coverage
Dental Benefits	No coverage
Short Term Disability Benefits	No coverage
Accidental Death and Dismemberment Insurance Benefits	No coverage

How Certain Services Are Covered under Comprehensive Medical Benefits

The Health Fund covers many Medically Necessary expenses. The following information along with the Schedule of Benefits provides more detail on how certain services are covered, limited or excluded from coverage. Certain services are subject to a preauthorization requirement (see page 21 for more information). The Plan does not restrict coverage for a pre-existing medical condition.

Acupuncture Care

See Chiropractic, Acupuncture and Naprapathic Care (Combined Benefit) on page 50.

Ambulance Service

The Plan covers professional ambulance service when used to transport you to the nearest Hospital for treatment. The Plan provides Medically Necessary transportation to another Hospital, rehabilitation facility, Extended Care/Skilled Nursing Facility or Hospice Facility.

Air or water ambulance is provided for Emergency transportation to the nearest facility for a life-threatening condition that dictates that the time needed to transport by ground ambulance would endanger health and/or survival, or the point of pick-up is inaccessible by a land vehicle.

Important: Charges in connection with travel for the patient's or the family's convenience, Hospital-to-home charges (unless Medically Necessary) and non-Emergency transports (except as mentioned above) are NOT covered.

Anesthesia or Sedation

The Plan covers Medically Necessary general anesthesia or sedation used in treatment of an Illness or Injury or an approved Medically Necessary dental procedure. In most cases, Dental benefits must be exhausted before anesthesia charges can be considered under the medical portion of the Active Plan (not applicable to the Low Cost Medical Plan).

General anesthesia or sedation for the convenience of the Covered Individual or Physician; or to alleviate fear, stress or anxiety is not covered.

Bariatric Surgery (also known as Gastrointestinal Surgery)

The Plan provides coverage for bariatric surgery for morbid obesity based on ***Medical Necessity***. To qualify for coverage of bariatric surgery, preauthorization through BCBSIL is required.

The Plan does not cover gastric stapling, gastroplasty, gastric banding or any other surgeries or procedures relating to weight reduction or obesity, including, but not limited to excess skin removal and complications resulting from any weight reduction surgery for which preauthorization through BCBSIL was not obtained.

Behavioral Health Care

The Plan covers Behavioral Health Care, including inpatient services in a Residential Treatment Facility and outpatient services such as outpatient therapy, diagnostic testing and partial hospitalization.

The Plan does not cover:

- Treatment for educational disorders related to learning, motor skills, communication and pervasive developmental conditions, except as allowed under the Physical, Occupational and Speech Therapies, as described on page 61.
- Services including custodial services, educational training, vocational rehabilitation, hypnosis, sleep therapy, employment counseling, back-to-school counseling, return-to-work services, work hardening programs, driving safety and services, training, educational therapy or nonmedical ancillary services for learning disabilities and ***Developmental Disabilities***, except as allowed under the Physical, Occupational and Speech Therapies, as described on page 61.
- Charges for treatment of a medical condition that are covered under any other portion of the Plan;
- Charges for treatment of a condition that requires care in a custodial facility or group home;
- ***Room and Board Charges*** beyond the discharge time;
- Private room charges for the patient's convenience; and
- Charges for personal services or items and guest food trays

Breast-Feeding Support and Equipment

The Plan covers counseling and ***Durable Medical Equipment (DME) and Supplies*** when provided through a PPO provider, including support and counseling for prenatal and postnatal lactation and equipment for a female Covered Individual who is lactating and requests a breast pump following the delivery date of a child.

The Durable Medical Equipment is covered as follows:

- Purchase of one breast pump and related initial supplies (tubing, shields and bottles);
- Rental of a Hospital-grade breast pump for the period a newborn is confined in the Hospital after the mother is discharged (generally, a Hospital-grade breast pump is not considered Medically Necessary once the newborn is discharged); or
- Rental of a Hospital-grade breast pump is considered Medically Necessary for up to 12 months of age for babies who have congenital disorders that interfere with feeding.

The Plan does not cover:

- Breast pumps purchased at a retail location;
- The purchase or rental of Hospital-grade breast pumps, unless Medically Necessary;
- Ongoing supplies, replacement tubing, bottles or storage bags, nursing bras, pads or creams;
- Services provided by individuals who are not licensed under state law to provide medical services or an individual who is not a certified lactation consultant; and
- Donor breast milk and all related services and fees.

Chiropractic, Acupuncture and Naprapathic Care (Combined Benefit)

The Plan covers chiropractic, acupuncture and naprapathic care, up to the benefit maximums as shown in the Schedule of Benefits, when performed by a licensed provider acting within the scope of his license.

Services rendered or provided by a chiropractor, acupuncturist or naprapath, including Office Visits, evaluations, X-rays, laboratory, orthotics, manual manipulations or adjustments, diathermy and all other therapeutic physical therapy modalities for musculoskeletal conditions will be considered and applied to the benefit maximum.

The Plan does not cover:

- Services for Dependent Children younger than age 12;
- Prescription drugs, nutritional supplements and homeopathic medicine(s);
- Educational materials, such as books or videos;
- Exercise equipment; and
- Services which are not consistent to the diagnosis.

Clinical Trials

The Plan does not cover clinical trials. However, the Plan does cover routine patient costs incurred in connection with certain approved clinical trials to the extent required under the Affordable Care Act. You must use a PPO provider if a PPO provider is participating in the approved clinical trial and the PPO provider will accept you as a participant in the approved clinical trial. The Plan does not otherwise cover charges for services or items defined by the Plan as ***Experimental or Investigational***.

Contraceptives

The Plan covers education, counseling and contraceptive methods for women with reproductive capacity, to the extent required under the Affordable Care Act, as follows:
The following FDA-approved contraceptives or contraceptive methods are covered under the Prescription Drug benefit when prescribed by a Physician:

- Generic oral contraceptives;
- Generic Emergency contraceptives;
- Patches; and
- Vaginal rings.
- The following FDA-approved contraceptives or contraceptive methods (including insertion and removal of devices and associated procedures), are covered under the Comprehensive Medical Benefit when prescribed by a Physician:
    - Diaphragms, sponges, cervical caps, female condoms and spermicide;
    - Intrauterine devices (IUDs);
    - Implants or implantable rods; and
    - Injectables.

The Plan does not cover:

- Brand-name oral contraceptives; and
- Abortion/abortifacient drugs.

Cosmetic Surgery

The Plan covers Cosmetic surgery to repair defects that result from a surgery, provided the subsequent repair is performed within one year from the date of the surgery that caused the defect.

The Plan does not cover:

- Cosmetic surgery that is not Medically Necessary or is performed solely to improve appearance;
- Charges for vein treatments that are Cosmetic or are not Medically Necessary; and
- Liposuction.

Dental Services for Accidental Injury to Teeth (Not Applicable to the Low-Cost Medical Plan)

The Plan covers dental services to repair tooth damage resulting from a proven accidental Injury that is not Work-Related, as follows:

- The Calendar Year maximum dental benefit must be exhausted.
- Dental damage must be severe enough that treatment was sought from a Doctor or Dentist within 48 hours of the accidental Injury.
- Repair of teeth must occur within one year from the date of the accidental Injury and is limited to teeth involved at the time of the accidental Injury.
- You must submit proof of the accidental Injury to the Health Benefits Department.

The Plan does not cover:

- Damage or Injury to teeth due to daily living activities, such as chewing and/or biting except as allowed under the Dental Plan; and
- Charges that exceed the Reasonable and Customary Allowance under the Plan or are related to orthodontic care, periodontics treatment, or preventive/diagnostic care, except as described in the Dental Benefits section.

Diagnostic X-Ray and Lab Tests

The Plan covers diagnostic X-rays and laboratory tests for services that are consistent with the diagnosis. The Plan does not cover pre-employment physicals.

Diagnostic Imaging

The Plan covers diagnostic imaging (MRI, CAT/CT, PET, bone scans, mammography, etc.) for services that are consistent with the diagnosis. The Plan does not cover routine charges outside the wellness care benefit as described on page 62.

Durable Medical Equipment (DME) and Supplies

The Plan covers DME and supplies from a licensed and accredited ***Durable Medical Equipment Provider*** when prescribed by a Physician. You must submit documentation establishing Medical Necessity for all DME purchases or rentals to the Health Benefits Department.

The repair, maintenance and replacement of equipment is based on Medical Necessity and limitations may apply. Sealed batteries required for electric wheelchairs are covered under the DME and Supplies benefit.

The Plan does not cover:

- Rental fees in excess of the purchase price for the DME;
- Non-sealed lead acid or alkaline batteries;
- Home modifications to accommodate equipment;
- Repair, maintenance or replacement of DME due to misuse or abuse;
- Replacement of DME that has been lost or stolen;

The Plan does not cover:

- Repairs, replacement and maintenance of rented items; and
- Charges for air purifiers, humidifiers, water purifiers, swimming pools, spas, saunas, escalators, lifts, motorized modes of transportation for patient convenience, pillows, mattresses, water beds, air conditioners, exercise equipment, exercise programs or for any personal convenience items that are not corrective devices or appliances.

Emergency Room Services

The Plan covers Emergency Room Services for a condition that:

- Results from symptoms that occur suddenly and unexpectedly;
- Requires immediate Physician care to prevent death or serious impairment of health; and
- Poses an imminent serious threat to you or to others.

For Emergency Room visits that do not require a Hospital admission, a Co-payment applies. The Co-payment will not apply if you are admitted to the Hospital as an inpatient within 72 hours of the Emergency Room visit for the same condition or held in the observation unit for more than 24 hours for the same condition. Non-PPO charges will be considered at the applicable PPO Coinsurance rate and subject to the Non-PPO Deductible.

The Plan does not cover charges for Emergency Room care incurred due to a Work-Related Illness or Injury.

Extended Care/Skilled Nursing Facility

The Plan covers Medically Necessary inpatient care following a hospitalization for a convalescent period in a facility that may be known as a Convalescent Facility, Extended Care Facility/Skilled Nursing Facility.

An “approved confinement” is one where the:

- Attending Physician certifies that such confinement and nursing care are Medically Necessary for recuperation from an Illness or Injury and that it is not for ***Custodial Care***;
- Confinement is due to an Illness or Injury that required and was preceded by at least three consecutive days of a Hospital confinement for which Plan benefits are payable;
- Confinement begins within 30 days after termination of a Hospital confinement or within 14 days after termination of an Extended Care/Skilled Nursing Facility confinement for which Plan benefits are payable;
- Assessment of the condition is performed by the attending Physician and skilled nursing staff (the first assessment must be within the first eight days); and
- The attending Physician continues to personally treat you and assessments are recorded on days 14, 30, 60 and 90 until you are discharged.

A new convalescent period starts when you are free of confinement for 60 days and are readmitted to the Hospital for a minimum of three consecutive days.

Covered services include:

- **Room and Board Charges**, including charges for services such as general nursing care made in connection with occupying a room; coverage is limited to the most common semi-private room rate.

- **Other Medically Necessary Services and Supplies**, including the use of special treatment rooms; X-ray and laboratory examinations; physical, occupational or speech therapy; medications, medical supplies and equipment used in the facility; medical social services; dietary counseling and Medically Necessary ambulance transportation to the nearest medical facility that renders needed services that are not available at the Extended Care/Skilled Nursing Facility.

The Plan does not cover personal services and items, guest food trays and private rooms for patient convenience.

Gastric Bypass Procedures

The Plan covers gastric bypass procedures for the diagnosis of bile reflux with bile gastritis.

Gender Affirming Care

The Plan covers gender affirming care consistent with BCBSI guidelines.

Genetic Testing

The Plan covers the following genetic testing, when ordered by a treating Physician:

- Genetic testing required under the Affordable Care Act, including Cologuard; and
- Diagnostic genetic testing.

The Plan does not cover genetic testing that is considered to be non-diagnostic. Non-diagnostic genetic testing includes, but is not limited to:

- Forensic testing used to identify an individual for legal purposes;
- Genetic testing used to determine the paternity of an individual;
- Genealogical testing used to determine the ancestry of an individual; and
- Genetic testing performed for the purpose of research.

Hearing Care (Not Applicable to the Low Cost Medical Plan)

The Plan covers charges for a:

- Hearing examination and related testing performed by a state licensed otologist or otolaryngologist or, as appropriate, another provider acting within the scope of his license; and
- Hearing aid instrument or its repair.

If you use a Non-PPO provider for services described above, you must file a claim with the Health Benefits Department or the Contracted Provider and submit a copy of itemized bills for the hearing exam and hearing aid indicating the name, model number, battery power and frequency response of the recommended hearing aid.

The Plan does not cover:

- Examinations and/or hearing aid instruments not prescribed by an otologist or otolaryngologist or, as appropriate, another provider acting within the scope of his license; and
- Hearing aid batteries.

Home Health Care

The Plan covers home health services and supplies in your home when ordered by a treating Physician and they are provided by a ***Home Health Agency*** to obtain a specified medical outcome. Each house call made by a member of the home health care team counts as one visit. Each house call up to four hours made by a home health aide also counts as one visit. However, if all visits are performed on the same day, by the same agency, they count as only one visit. Medically Necessary home health services provided in your home as an appropriate cost- effective alternative to care in another setting (such as a Hospital, inpatient Skilled Nursing Facility or long-term care facility), include:

- Physical, occupational, respiratory and speech therapy when used to restore loss of an established function caused by an Illness or Injury;
- Medical supplies, DME, prescription drugs, enteral feeding, diagnostic X-ray and laboratory tests for services, if these services and supplies would have been covered had you been confined in a Hospital or Convalescent Facility;
- Skilled nursing care on a part-time or intermittent basis, including services and care that can only be performed safely and effectively by a licensed nurse (either a Registered Nurse [RN] or Licensed Practical Nurse [LPN]), licensed vocational nurse [LVN] or another provider acting within the scope of the provider's license); including Private Duty Nursing (limited to 120 visits per Calendar Year); and
- Medical social services, under the direction of a Physician.

A written Treatment Plan must outline treatment goals and be submitted with the request for specific services and supplies. Periodic review of the Treatment Plan and progress toward those goals may be required.

The Plan does not cover:

- 24-hour-a-day home health care;
- Home delivery of meals;
- Homemaker services, such as shopping, cleaning and laundry, when this is the only care needed and when these services are not related to your Treatment Plan;
- Custodial care, domiciliary care, respite care, rest cures or personal care given by a home health aide such as bathing, dressing and using the bathroom when this is the only care provided.

Hospice Care

The Plan covers ***Hospice*** care if a Physician certifies the Covered Individual has six months or less to live with a condition that would benefit from Hospice care at home, in an outpatient setting or in an institutional setting that is approved by Medicare as an approved Hospice program. The Plan provides Hospice care benefits beginning on the date your attending Physician certifies a diagnosis of terminal illness and you are accepted into a Hospice program.

Covered hospice care expenses include Room and Board Charges, up to the facility's semiprivate room rate and other services and supplies including Doctor services, nursing care and equipment, supplies and prescription drugs for pain management.

The Plan does not cover:

- Room and Board Charges if Hospice services are provided in the home;
- Long-term inpatient care;
- Prescription drugs to cure an Illness;
- Administrative services;

The Plan does not cover:

- Homemaker or caretaker services and any services or supplies not solely related to the care of a Covered Individual, including sitter or companion services for the Covered Individual who has an Illness, house cleaning, general maintenance of the Covered Individual's home or childcare;
- Transportation, except when Medically Necessary;
- Any services or supplies not provided as core services by the Hospice program providing the Hospice care;
- Home-delivered meals;
- Funeral arrangements;
- Pastoral or bereavement counseling; and
- Respite care services.

Hospital Care

The Plan covers Hospital care as follows:

- Inpatient Hospital including a semi-private room with nursing services and supplies, nursery charges for newborns and all operating rooms and supplies, equipment, appliances and drugs as furnished for care. Charges for a private room if Medically Necessary for conditions that include, but are not limited to, contagious or communicable diseases;
- Outpatient Hospital, including services and supplies otherwise provided on an inpatient Hospital basis, facility fees for outpatient surgery and treatment including X-rays, radium therapy and other radioactive substances, chemotherapy, laboratory and diagnostic radiology and imaging.
- Dental services for certain dental procedures that are preauthorized and approved by the Health Benefits Department before services are rendered. Not applicable to the Low Cost Medical Plan.

The Plan does not cover:

- Room and Board Charges beyond the discharge time;
- Charges for personal services or items and guest food trays;
- Hospital admission charges solely for X-rays, laboratory, electrocardiographic examinations or physical therapies;
- Private rooms or private nursing charges for patient convenience; and
- Charges for medical records or to review medical records, write evaluations or special reports, to complete school, camp or immunization records, or to complete Claim forms.

Infertility

The Plan covers infertility services and supplies for the diagnosis and treatment of infertility or the promotion of conception for you, the Employee, and your spouse. Infertility prescription drugs are covered under the Plan's Comprehensive Medical Benefits, subject to applicable PPO and Non-PPO Deductibles and Coinsurance. Genetic testing is covered under the Plan's Genetic Testing benefit.

The Plan does not cover:

- Reversal of an elective sterilization procedure;
- Infertility treatments after the reversal of an elective sterilization procedure;
- Medical services rendered to a surrogate for purposes of childbearing when the surrogate is not a Covered Individual

The Plan does not cover:

- Any services, supplies, or medical expenses related to surrogacy when the Covered Individual (Employee, spouse, or dependent) is acting as a surrogate for a person who is not covered under this Plan;
- Cryopreservation or similar procedures for the storage of sperm, eggs and embryos;
- Any expenses incurred by an egg or sperm donor;
- Harvesting of eggs or semen from a donor other than you or your spouse;
- Infertility treatments that are Experimental or Investigational in nature;
- Ovulation kits, sperm testing kits and supplies; and
- Infertility treatment or services for a Dependent child.

Infusion Therapy

The Plan covers ***Infusion Therapy*** ordered by a Physician, including the services and supplies required. In general, if a medication is administered in a Physician's office rather than an infusion center, the medication should be obtained through Diplomat Specialty Pharmacy, the Fund's Contracted Provider for specialty drugs. In most cases, chemotherapy drugs received by infusion are covered under the Plan's Comprehensive Medical Benefits. The Plan does not cover wellness infusions or infusions of vitamins or iron.

Naprapathic Care

See Chiropractic, Acupuncture and Naprapathic Care (Combined Benefit) on page 50.

Nutritional Counseling

The Plan covers nutritional counseling for chronic diseases as required by the Affordable Care Act as ordered by a Physician or, if appropriate, another provider acting within the scope of his license. The services may be rendered by a registered dietician, a Medicare-approved nutrition professional or another Network Provider acting within the scope of his license for the treatment of obesity, diabetes, prediabetes, cardiovascular and kidney disease, eating disorders, gastrointestinal disorders, chronic obstructive pulmonary disease, hypertension, seizures and cancer.

Oral and Maxillofacial Surgery

The Plan covers oral and maxillofacial surgery by a Doctor of Medicine (MD) or, as appropriate, another provider acting within the scope of his license, for Medically Necessary services as follows:

- Excision and/or biopsy of tumors and cysts of the jaw, cheek, lip, tongue, roof and floor of the mouth. An explanation of benefits must be received from the Contracted Dental Provider indicating that the excision or biopsy has not been covered or only partially covered through the Contracted Dental Provider. An excision and/or biopsy will be covered through either the Contracted Dental Provider or through the Comprehensive Medical Benefits;
- Removal of teeth which is necessary to perform radiation therapy as treatment of oral and/or facial cancer;
- Stabilization of facial bone fractures;
- External excision and drainage of abscess (cellulitis);
- Surgery of accessory sinuses, salivary glands or ducts;
- Resection of osteomyelitis; and
- A frenulectomy

The Plan does not cover:

- Orthodontic, periodontics, endodontic and prosthetic services;
- Dental services, including:
  - Restorative care to the dentition including crowns, fillings, bridges, partial and full dentures;
  - Occlusal adjustments or equilibration to the teeth, unless for the treatment of temporomandibular joint (TMJ) disorder (see page 60);
  - Dental applications, including bite splints and metal-based occlusal appliances;
  - Extraction of unerupted or partially erupted, malpositioned or impacted teeth;
  - Surgical preparation of mouth for dentures;
  - Surgeries for gum disease or orthodontic treatment;
  - Alveolectomy and alveoplasty;
  - Frenulectomy when performed by a dentist;
  - Vestibuloplasty;
  - Services for oral surgery procedures performed by a dentist; and
  - Unsubstantiated or unproven accidental injuries.

Organ Transplants

The Plan covers organ and tissue transplants, including procurement, surgery and complications that result from the procurement and surgery.

The Plan covers living donor expenses associated with living donor evaluations, the donation surgery procedure and required postoperative care when the recipient is covered by the Fund.

The Plan does not cover:

- Transplants that are experimental or investigational;
- Donor charges when the recipient is not covered by the Fund;
- Expenses for treatment of any other donor health-related concerns that may be identified during the donor evaluation process;
- Expenses that fall outside the transplant donor evaluation, such as, but not limited to, annual physicals, travel, lodging, lost wages and other non-medical expenses;
- Costs of anti-rejection drugs following discharge, other than those covered under the Prescription Drug benefit; and
- Charges incurred by organ donors that are not related to the original donor transplant procedure or complications that result from such surgeries, procedures, or treatments.

Physician Services

The Plan covers services provided by a Physician, as defined in the Glossary.
The Plan does not cover:

- Services that are inconsistent with the diagnosis;
- Charges for medical records or to review medical records, write evaluations or special reports, to complete school, camp or immunization records, or to complete Claim forms;
- Multiple charges for Office Visits for the same condition or diagnosis from the same Physician for the same date of service;
- Charges for telemedicine or virtual appointments;
- Charges for telephone or email consultations or interviews; and
- Charges for missed appointments.

Pregnancy Care

Obstetrical, pre and post-natal care and delivery are covered when provided by a Physician or a Certified Nurse Midwife. For lactation coverage, see Breast-Feeding Support and Equipment on page 50. For genetic testing coverage, see Genetic Testing on page 54.

The Plan does not cover:

- Prenatal classes;
- Services provided by a doula, unless licensed by a recognized state licensing entity;
- Home pregnancy tests;
- Paternity testing; and
- Non-prescription prenatal vitamins.

Professional Chaperones

The Plan covers the cost of a professional chaperone when needed during an Office Visit that includes an intimate medical exam. An intimate medical exam involves an examination of the breasts, genitals, or rectum to diagnose or monitor a medical condition.

Prosthetics

The Plan covers artificial limbs, including artificial legs, arms and eyes when prescribed by a Physician. The Plan also covers hair prosthesis, including a wig or hairpiece due to hair loss from chemotherapy or radiation therapy resulting from a cancer diagnosis (not applicable to the Low Cost Medical Plan). The Plan may cover replacement prosthetics if determined to be Medically Necessary.

The Plan does not cover:

- Hair transplants, hair plugs or hair weaves;
- The cost of maintenance for a wig, hairpiece or scalp prosthetic, including styling and cleaning;
- Diagnostic or therapeutic methods intended to encourage hair regrowth;
- Wigs, hairpieces or other scalp prosthetics for hair loss caused by something other than a cancer diagnosis; and
- Replacements due to loss or theft.

Reconstructive Breast Surgery

The Plan covers post-mastectomy reconstructive surgery and breast prosthesis, without regard to the time elapsed since the mastectomy, as follows:

- Reconstruction of the breast or aesthetic flat closure surgery on which the mastectomy was performed;
- Surgery and reconstruction of the other breast for the purpose of achieving reasonable breast symmetry; and
- Prostheses and treatment for physical complications at all stages of the mastectomy, including lymphedemas, in a manner determined in consultation with the attending provider and the patient.

Sterilization

The Plan covers elective sterilization, as shown in the Schedule of Benefits. The Plan does not cover reversal of a sterilization procedure or sterilization for a Dependent child, except as required by the Affordable Care Act.

Substance Use Disorders

The Plan covers inpatient and outpatient Covered Services for treatment of Substance Use Disorders, including inpatient services in a Residential Treatment Facility and outpatient services such as outpatient therapy, diagnostic testing and partial hospitalization.

The Plan does not cover:

- Charges for treatment of a medical condition that is covered under any other portion of the Plan;
- Care in a custodial facility or group home;
- Room and Board Charges beyond the approved discharge time;
- Private room charges for the patient's convenience; and
- Charges for personal services or items and guest food trays.

Surgi-Centers

The Plan covers Surgi-Center services and supplies only when you use a PPO Surgi-Center, or a Surgi-Center affiliated with a Hospital, whether PPO or Non-PPO Hospital. The Plan does not cover any freestanding Non-PPO Surgi-Center facilities that are not affiliated with a Hospital.

Surgical Assistants and Assistant Surgeons

The Plan covers fees for surgical assistants and/or assistant surgeons when the surgical procedure warrants the necessary assistance of another Physician (assistant surgeon) or other trained personnel such as a Physician Assistant (PA) or Registered Nurse First Assistant (RNFA) acting within the scope of their license.

Surgical Consultations

The Plan covers charges for a surgical consultation and associated laboratory or X-ray examinations.

Temporomandibular Joint (TMJ) Dysfunction

The Plan covers the following services and supplies for the diagnosis and treatment of temporomandibular joint (TMJ) disorders:

- Diagnostic imaging procedures;
- Physical or occupational therapy;
- Appliances and their adjustments for TMJ and bruxism (occlusal);
- Non-surgical treatments; and
- Surgical procedures, including related hospitalization.

The Plan does not cover treatment of restorations of the dentition, supporting tissues and bone.

Urgent/Immediate Care Facilities and Retail Clinics

The Plan covers Urgent/Immediate Care Facilities and Retail Clinics for conditions that are not life-threatening. You may be able to save time and money by going to your local PPO Urgent/Immediate Care Facility or Retail Clinic. These types of facilities allow walk-ins, have extended hours, their Doctors can treat non-life-threatening medical situations, perform basic X-rays and lab work and prescribe prescription drugs.

You can locate a PPO Urgent/Immediate Care Facility or Retail Clinic by calling BCBS at 800-810-2583 or you can log on to their website at bcbsil.com.

Therapy Services (Outpatient Physical, Speech and Occupational)

The Plan covers outpatient physical, speech and occupational therapies as described below:

- **Restorative/Rehabilitative Therapy**: The Plan covers outpatient physical, speech and occupational therapies up to the benefit maximums shown in the Schedule of Benefits. After the benefit maximum has been reached, no other payment is made under the Plan with the following exception: If the maximum benefit is reached for the outpatient treatment of cerebral palsy, cerebral vascular incident (stroke), intracranial bleed or other head traumas, spinal cord injuries, multiple or complicated fractures or other catastrophic diagnoses with neurological implications, significant or multiple injuries and/or illnesses. Medical records will be required for additional benefit consideration.
- **Developmental Delay/Habilitative Therapy**: Developmental Delay/Habilitative Therapy: The Plan covers Medically Necessary outpatient habilitative (to teach) physical, occupational and speech therapies for eligible dependents through age 18 diagnosed with Developmental Disabilities. Before the Plan will consider benefits, you must submit to the Health Benefits Department a letter of medical necessity and supporting documentation from the attending Physician for the therapies prescribed. Supporting documentation may include, but is not limited to, the initial evaluation, Treatment Plan, and/or progress notes.

Vision Surgery

The Plan covers vision surgery (e.g., glaucoma, cataract surgery). The Plan does not cover vision surgery and related expenses for correction of refractive disorders, refractive lenses, refractive keratoplasty procedures and Cosmetic blepharoplasty.

Wellness Care

The Plan covers certain wellness care services at 100% if a PPO provider is used. The Plan intends to comply with all preventive care requirements of the Affordable Care Act.

- The Plan covers preventive items or services with an A or B rating as recommended or defined by the U.S. Preventive Service Task Force, immunizations recommended by the Centers for Disease Control (CDC), preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration (HRSA) and screenings for women supported by the HRSA subject to the following:
  - Wellness care services required under the Affordable Care Act are not payable under other portions of the Plan.
  - The Plan will use reasonable medical management techniques to control costs of wellness care services provided under the Affordable Care Act.
  - If a wellness care item or service is billed separately from an office visit, and the primary purpose is not the delivery of the wellness care item or service covered under the Affordable Care Act, then the Plan will impose the applicable Deductible and Coinsurance for the Office Visit.
  - Wellness and preventive care does not cover the following services, unless otherwise required under the Affordable Care Act:
    - » Services related to a symptomatic or diagnostic condition;
    - » Examinations and tests to diagnose or verify a pregnancy;
    - » Premarital examinations;
    - » Paternity testing;
    - » Pre-employment physicals;
    - » Services that are not consistent with preventive services, as defined by the Affordable Care Act;
    - » Additional testing or services to confirm an Illness or Injury diagnosed as a result of a wellness care examination or procedure;
    - » Wellness care services under the Affordable Care Act are covered when performed for preventive screening reasons and billed under the appropriate preventive services codes. Other services are covered under the applicable Plan benefit, not the wellness care benefit; and
    - » Travel immunizations (e.g., typhoid, yellow fever, cholera, plague and Japanese encephalitis virus) are not covered.
- Smoking cessation interventions based on requirements under the Affordable Care Act. For more information, contact Pelago at 877-349-7755 or to enroll online visit ***my.pelagohealth.com/carpenters.***

What Is NOT Covered under Comprehensive Medical Benefits

The exclusions below are not all-inclusive, because exclusions will be applied based on facts and circumstances of each claim. Pages 49-62 list specifics on how the Plan covers certain services, as well as limits and exclusions that apply to those services. In general, no benefits are payable under the Plan for the following:

- Any expenses incurred during a period in which you or a Dependent are not eligible for benefits under the Plan.
- Any expenses incurred by a person who does not meet the Plan's definition of a Covered Individual.
- Charges for services or supplies that exceed the Reasonable and Customary Allowance.
- Charges that would not have been made if no coverage existed or charges that you would not be required to pay.
- Expenses that may result from your failure to use an HMO provider when required to do so by another insurance plan.
- Charges that exceed the various benefit maximums that apply to the different benefits under this Plan.
- Charges for services and supplies that are:
  - Not Medically Necessary for treatment of a Non-Occupational Illness or Injury;
  - Inconsistent to the diagnosis;
  - Inconsistent with industry standards; or
  - Not recommended, performed or approved by the attending Physician; or another provider acting within the scope of his license.
- Charges incurred due to any Occupational Illness or Injury sustained while performing any act of employment or doing anything pertaining to any occupation or employment for remuneration or profit.
- Charges for items defined by the Plan as Experimental or Investigational. However, to the extent required under the Affordable Care Act, the Plan will not deny you the right to participate in certain approved clinical trials; deny, limit or impose additional conditions on the coverage of routine patient costs furnished in connection with participation in the clinical trial; and will not discriminate against you for participating in the clinical trial. For more information on clinical trials, see page 51 or contact the Health Benefits Department.
- Expenses excluded under the Plan's Coordination of Benefits provisions.
- Charges in connection with the services of blood donation, storage of autologous blood or umbilical-cord blood banking.
- Charges for physical examinations required for employment purposes or court-ordered examinations.
- Food supplements or baby formulas, unless:
  - Administered through a feeding tube or
  - Orally with the diagnosis of: eosinophilic gastroenteritis, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia, methylmalonic acidemia, urea cycle disorders, phenylketonuria, Crohn's disease, ulcerative colitis, gastrointestinal dysmotility, gastroesophageal reflux, chronic intestinal pseudo-obstruction, or other organic and amino acidemias.
- Penile implants, erect-aids or erectile enhancement prescription drugs, except if the prescription drugs are prescribed as a Medically Necessary Treatment Plan for an Illness, other than impotency.
- Premarital examinations or counseling.
- Paternity testing.
- Expenses of an elective abortion or the abortion pill, except when the mother's life is in danger as determined by a medical diagnosis, or in instances of verifiable rape or incest.

- Personality or emotional testing and/or examinations, except to the extent specifically covered by the MAP or under the Behavioral Health and/or Substance Use Disorders benefit.
- Charges for bereavement counseling, pastoral counseling, financial or legal counseling, and funeral arrangements, except to the extent covered by the MAP.
- Vitamin supplements, except to the extent required under the Affordable Care Act.
- Colonics or homeopathic remedies or procedures.
- Vitamin K-1, except when used to counteract a prescription blood thinner such as Warfarin or Coumadin.
- Vitamin B-12 injections, except for treatment of pernicious anemia and cancer-related chemotherapy.
- Charges for massage therapy, unless prescribed for therapeutic purposes to treat an Illness or Injury in a clinical setting. Massage therapists are not covered.
- Charges for hypnosis therapy.
- Charges for chelation therapy, except when approved by the FDA as an appropriate Medically Necessary course of treatment. Prior authorization and appropriate laboratory testing may apply.
- Charges for smoking cessation therapies or products, except to the extent required under the Affordable Care Act or covered by the smoking cessation program.
- Charges for hair prostheses, wigs, toupees, hair implant plugs or hair loss products, except for wigs, hairpieces or hair prosthetics for hair loss due to chemotherapy or radiation treatment after a cancer diagnosis (not applicable to the Low Cost Medical Plan).
- Charges for treatment of alopecia or hirsutism.
- Charges for excessive hair removal, electrolysis, depilatories or other hair removal treatments and products.
- Charges for care or treatment in a health resort, at an alternative medical center or a holistic center.
- Charges for homemaker or caretaker services, such as sitter or companion services, transportation, housecleaning and house maintenance.
- Custodial care.
- Instruction, classes or testing relating to motor vehicle accidents.
- A non-covered dental expense will not be covered under Comprehensive Medical Benefits, unless it is the result of a traumatic injury.
- Charges for services or supplies that are paid for or otherwise provided for under any law of a government, except where the payments or the benefits are provided under a plan specifically established by a government for its own civilian employees and their dependents.
- Charges for services or supplies that are furnished, paid for or otherwise provided for, by reasons of past or present service of any person in the Military Service.
- Charges from a Veterans Administration Hospital or a Physician employed by such Hospital when the Veterans Administration Hospital has the responsibility to provide the service or care for an Illness or Injury related to Military Service.
- Charges for treatment that requires care in a group home.
- Expenses for or related to Gene Therapy and/or Gene-Based Cell Therapy.

What Is NOT Covered under the Vision Benefit

The exclusions listed below are not all-inclusive and are representative only of the type of charges for which benefits are limited or not payable under the Plan's Vision benefit; however, some items listed below may be covered under the Comprehensive Medical Benefits.

- Special procedures, such as orthoptics or vision training and special supplies or non- prescription sunglasses and sub-normal vision aids.

- Visual fields analysis, which does not include refraction.
- All vision surgeries.
- Expenses for artificial eyes.

What Is NOT Covered under the Dental Benefit

- The exclusions listed below are not all-inclusive and are representative only of the type of charges for which benefits are limited or not payable under the Plan's Dental benefit; however, some items listed below may be covered under the Comprehensive Medical Benefits.
- Services compensable under Workers' Compensation or Employers' liability laws.
- Treatment, including prosthetics, which were started before the date a Covered Individual became eligible under the Active Plan.
- Any service for which coverage is not specifically provided under the Plan's Dental benefit, including Hospital or prescription drug charges except as covered under Comprehensive Medical Benefits.
- Temporary restorations.
- Services performed for Cosmetic purposes (such as teeth whitening).
- Replacement of a dental appliance (prosthetic) due to loss or theft.
- Occlusal, bruxism and TMJ appliances and adjustments, except as covered under Comprehensive Medical Benefits on page 60.
- Treatment of oral and/or facial cancer.
- Treatment of fractures of facial bones.
- External excision and drainage of an abscess.
- Surgery of accessory sinuses, salivary glands or ducts.
- Resection of osteomyelitis.
- Emergency facility care to stabilize dental structures following an acute Injury to teeth, except as covered under Comprehensive Medical Benefits.
- Services provided or paid for by any governmental agency or under any governmental program or law, except as to charges that the person is legally obligated to pay. This exception extends to any benefits provided under the U.S. Social Security Act and its amendments.
- Services covered under any other group program or employer, Union or association sponsored program, to the extent that more than 100% recovery would be made for any charges that are at least partially covered under any one or more of such programs, including this Plan.

What Is NOT Covered under the Prescription Drug Benefit

The Plan does not cover:

- Prescription drugs, indications and/or dosage regimens determined to be not Medically Necessary or Experimental, Investigational or unproven medication or therapies, or drugs not approved by the United States Food and Drug Administration (FDA) for the intended use (off label).
- Prescription drugs requiring prior authorization that are dispensed without prior authorization from the Contracted Provider.
- Any medication prescribed in a manner other than in accordance with criteria developed by the Contracted Provider.
- Erectile dysfunction drugs, except if Medically Necessary and prescribed as a Treatment Plan for an Illness, other than erectile dysfunction.
- Drugs or medicines lawfully obtainable without a prescription from a Physician or Dentist except to the extent required under the Affordable Care Act.
- Therapeutic devices, support garments or other appliances regardless of their intended use.

- Any charges for the administration of a prescription drug.
- Medication that is to be taken by or administered to the Covered Individual, in whole or in part, while a patient in a licensed Hospital, Extended Care/Skilled Nursing Facility or similar institution that operates a facility for dispensing pharmaceuticals on its premises or allows to be operated on its premises, except as provided for in the exception for Extended Care/Skilled Nursing Facilities.
- A prescription in excess of the quantity specified by the Physician or dentist, or maximum allowed by the Contracted Provider, or any refill dispensed after one year from the order of a Physician or Dentist.
- Prescription drugs that may be properly received without charge under local, state or federal programs, including Workers' Compensation.
- Weight loss drugs.
- Smoking cessation products, except as coordinated with Pelago or as required for preventive care under the Affordable Care Act.
- Drugs to stimulate hair growth.
- Infertility drugs (when treatment of infertility is covered, infertility prescriptions are covered under Comprehensive Medical Benefits).
- Acne drugs for cosmetic reasons.
- Vitamins, food supplements, infant or homeopathic drugs except as specifically coverage (see page 59).
- Growth hormones unless Medically Necessary, as determined by the Contracted Provider and obtained through the Specialty Care Pharmacy Program.
- Expenses for or related to Gene Therapy and/or Gene-Based Cell Therapy.

What Is NOT Covered under the Hearing Care Benefit

The Plan does not cover:

- Examinations and/or a hearing aid instrument not prescribed by an otologist or otolaryngologist or, as appropriate, another provider acting within the scope of his license; and
- Hearing aid batteries

Claims and Appeals

This section describes the procedures for filing claims for benefits from the Plan. It also describes the procedures for you to follow if your claim is denied, in whole or in part, and you wish to appeal the decision.

Required Procedures

When you are first eligible for benefits and thereafter on an annual basis or upon request, you must complete certain required procedures that validate census data including information about your spouse, Dependent child(ren), and other insurance coverage. Coverage will not be considered for Dependents until the requirements are fully completed and accepted by the Health Benefits Department.

As described on page 5, you must update information on file with the Fund Office by notifying the Fund Office or submitting the update through the Member Portal as soon as possible after any change. Coverage may be delayed or terminated if the update and any supporting documents are not received in a timely manner.

General Rules Governing Claims

Covered Individuals and providers may submit Claims in paper form or through Electronic Data Interchange ("EDI"). Claims must be submitted to the Plan's Contracted Provider of service.

If a Covered Individual's provider and service(s) were obtained outside the Contracted Provider's Network area, the provider must file the Claim with the Contracted Provider or the local affiliate of the Contracted Provider, if applicable.

Each Claim must include:

- Patient name and date of birth;
- The Participant's name and Social Security number or other ID number assigned by the Fund;
- Date of service or date of fill or refill for prescription drug Claims;
- Specific services performed and expenses charged for each service;
- Diagnosis and type of service defined by HCPCS, CPT, ICD, CDT, or other nationally recognized codes, including individual charges for each service;
- Attending Physician's or care provider's name and federal tax ID number (not required for prescription drug Claims);
- Place of service;
- Billing address; and
- Previous balances paid.

A Covered Individual must pay any amounts not paid by the Fund, with the exception of PPO Network discounts or discounts that may be negotiated between the Plan and the provider on Out-of-Network Claims. PPO or other negotiated discounts do not apply to expenses that are not covered by the Plan.

A Covered Individual is prohibited from assigning his rights under the medical portion of the Plan to a third party or in any way alienating the Covered Individual's Claims for benefits. Any attempt to assign rights or in any way alienate a Claim for benefits will be void and will not be recognized by the Fund as an assignment. The Fund will treat any document attempting to assign your rights, or to alienate a Claim for benefits to a provider, as an authorization for direct payment by the Fund to the provider. In the event that the Fund receives a document claiming to be an assignment of benefits, the Fund may send payments for the

Claims to the provider, but will send all Claim documentation, such as an explanation of benefits, and any procedures for appealing a Claim denial directly to the Covered Individual. If the Fund denies the Claim, only you, your spouse, the patient or his Authorized Representative will have the right to appeal.
The Fund will pay Claims only when covered under the terms of the Plan provisions under which a Covered Individual is eligible. If the Fund pays claims that it is not required to pay, it may recover and collect payments from a Covered Individual or any other entity or organization to whom the Fund was not required to make the payment or that received an erroneous payment. The Fund may recover such erroneous payments through, but not limited to, an offset or reduction of any future benefits a Covered Individual, or other eligible Dependent(s), may be entitled to receive from the Fund. The Fund shall be permitted to pursue legal and equitable remedies to recover overpayments.

For purposes of this section, the Claims Fiduciary means the entity that has full discretionary authority to interpret the terms of the Plan and to decide benefit Claims under the Plan and the appeal of such decision, and to maintain any applicable external review process. The Plan's Claims Fiduciary is the Board of Trustees unless the Trustees take action to delegate such authority to a third party Claims Fiduciary, such as to an insurance carrier or to a third party service provider responsible for maintaining a benefit program under the Plan.

Please note that the Trustees have designated Claims Fiduciaries for the Plan who have the authority to decide and review all benefit Claims and all denied Claims upon appeal under the Plan as follows:

- Fund Office for enrollment, eligibility, premium payments, medical Claims, Short Term Disability Claims, Maternity Leave Claims, and Vacation Savings Plan Claims.
- Delta Dental of Illinois for dental Claims.
- Express Scripts, Inc. for prescription drug Claims.
- Accredo Specialty Pharmacy for specialty drug Claims.
- VSP for vision Claims.
- MetLife for life insurance and accidental death and dismemberment Claims.
- Optum Financial for Health Reimbursement Account Claims.

Please see Important Contact Information on page 7 for telephone numbers and website addresses.

The above Claims Fiduciaries are named fiduciaries under the Active Plan and have the authority to make final decisions regarding Claims for benefit consideration under the Plan.

Authorized Personal Representative
You may designate an ***Authorized Personal Representative*** to act on your behalf by notifying the Health Benefits Department and completing and submitting an Authorized Personal Representative Form or other form or procedure required by a designated third-party Claims Fiduciary. Only the Authorized Personal Representative Form issued by the Fund or other form or procedure required by a designated third-party Claims Fiduciary will be accepted. If an Authorized Personal Representative is designated, correspondence relating to the claim or subsequent appeal may be shared with the designated Authorized Personal Representative, unless otherwise specified. **An individual who holds a health care power of attorney is deemed an Authorized Personal Representative.**

Only the Authorized Personal Representative Form issued by the Fund or other form or procedure required by a designated third-party Claims Fiduciary will be accepted.

You may obtain an Authorized Personal Representative Form from the Fund's website at ***carpenterbenefits.org***, or by calling 312-787-9455. To inquire regarding necessary forms or procedures for designating an Authorized Personal Representative for benefits administered on behalf of the Plan through a third party, please contact the appropriate service provider listed on page 7 of this Summary Plan Description.

Types of Claims

There are several basic types of Claims under the Plan:

- **Health Care Claims** include Medical, prescription drug, dental, hearing, and vision Claims. Health Care Claims fall into the following categories:
  - **Pre-Service Health Care Claim**: Any Claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before the Covered Individual obtains medical care;
  - **Urgent Health Care Claim**: A subset of pre-service health care Claims for which the application of the periods for making pre-service Claim determinations would, in the opinion of a Physician with knowledge of the Covered Individual's condition, seriously jeopardize the Covered Individual's life or health or ability to regain maximum function if normal pre-service standards were applied; or would subject the Covered Individual to severe pain that cannot be adequately managed without the care or treatment for which approval is sought;
  - **Post Service Health Care Claim**: Any claim for health care benefits for which the Covered Individual has already received the services in the Claim; and
  - **Concurrent Care Claim**: Any Claim that is reconsidered after it is initially approved and the reconsideration results in reduced benefits, an extension of benefits, or a termination of benefits.
- **Short Term Disability Claims**
- **Other Benefit Claims**, which include Maternity Leave, Vacation Savings Plan, Life Insurance benefits and Accidental Death and Dismemberment benefits.

Submission of Claims

Claims may be submitted in paper form specified by the designated Claims Fiduciary or through Electronic Data Interchange. A provider may submit a Claim on the Claimant's behalf. Claims recognized under the Plan include requests for:

- Medical benefits, when accompanied by a Hospital, Physician, prescription, dental, hearing, or vision bill; or other type of invoice that includes the details specified on page 63;
- Short Term Disability benefits, when accompanied by a Claim form completed by you and your attending Physician;
- Maternity Leave benefits, when accompanied by a Claim form completed by you and your attending Physician;
- Vacation Savings Plan benefits; or
- Life Insurance and/or Accidental Death and Dismemberment benefits, when accompanied by a certified death certificate and/or other required documentation as required by the Insurance Company or Fund Office.

Incomplete Claims: If the Plan receives a document or transmission that contains, at a minimum, the following six items, it will be considered a Claim, even if additional information is required to process the Claim. If additional information is required, the Claimant will receive an extension for filing the Claim.

- Patient name and date of birth;

- Participant name and Social Security number or other ID number assigned by the Fund Office;
- Date of service or date of fill or refill for prescription drug Claims;
- Specific services performed and itemized charges for each service;
- Diagnosis and type of services as defined by HCPCS, CPT, ICD, CDT, or other nationally recognized codes, including individual charges for each service; or
- Attending Physician's or care Provider's name and federal tax ID number (not required for prescription drug Claims).

Items not treated as Claims for benefits include any general inquiry about benefits or the circumstances under which benefits might be paid under Plan terms.

When a Claim Must Be Filed

A Claim for benefits must be filed with the designated Claims Fiduciary within 24 months from the date of service, or other period specified by a third-party Claims Fiduciary.

Processing Procedures for Initial Claims

When a Claim is submitted for benefits, the Fund Office or the designated third-party Claims Fiduciary on behalf of the Trustees will determine if the Covered Individual is eligible for benefits and will calculate the amount of any benefits payable.

The deadlines for processing the initial determination of a Claim vary by Claim type, as follows:

- **Health Care Claims**
  - Urgent Health Care Claims: Within 72 hours of receipt of the Claim.
  - Pre-Service Health Care Claims: Within 15 days of receipt of the Claim.
  - Post-Service Health Care Claims: Within 30 days of receipt of the Claim.
- **Concurrent Care Claims**: As soon as possible and in time to receive a decision before reduction or termination of the benefit.
- **Short Term Disability Claims** will be determined within 45 days of receipt of the Claim.
- **Other Benefit Claims** (Maternity Leave, Vacation Savings, Life Insurance and Accidental Death and Dismemberment) will be determined within 90 days of receipt of the Claim.

Extension of Initial Determination Period: In some instances, an extension of the initial determination period may be required due to matters beyond the Claims Fiduciary's control. The Claimant will be notified by the Claims Fiduciary if an extension is necessary. The Claims Fiduciary's notice will include the special circumstances requiring the extension and the date the Claims Fiduciary expects to render a decision, as follows:

- **Urgent Health Care Claims**: The deadline for urgent health care claims cannot be extended.
- **Pre-Service Health Care Claims**: The Claimant will be notified within the 15-day initial determination period that one 15-day extension is necessary.
- **Post-Service Health Care Claims**: The Claimant will be notified within the 30-day initial determination period that one 15-day extension is necessary.
- **Short Term Disability Claims**: The Claimant will be notified within the 45-day initial determination period that up to an additional 30 days maximum is necessary. If a determination is not made within the first 75 days, the Claimant will be notified that an additional 30 days is necessary.

- **Other Benefit Claims**: The Claimant will be notified within the 90-day initial determination period that up to an additional 90 days may be necessary. The extension cannot be more than 90 days from the end of the initial 90-day period, or 180 days total.

The Claimant will be notified when additional information is needed to process a claim, as follows:

- **Health Care Claims**: Within the 15-day or 30-day initial determination period. The Claimant (or his provider, if his provider is notified) has up to 45 days to provide the requested information. If the Claims Fiduciary receives the requested information in the 45-day period, the Claim will be processed within 15 days following the receipt of the additional information. For an Urgent Care Claim, the deadline for additional information is as soon as possible but within 24 hours of the receipt of the Claim. The Claims Fiduciary must notify the Claimant of the specific information needed and the Claimant has at least 48 hours to provide the information.
- **Claims for Short Term Disability Benefits**: Within the 45-day initial determination period. The Claimant has up to 45 days to provide the requested information.
- **Other Benefit Claims**: Within the 90-day initial determination period. The 90-day extension of the initial determination period listed above includes any time needed by the Claims Fiduciary to obtain this information.

If a Claim is denied, in whole or in part, the Claims Fiduciary will provide the Claimant a written notice of the Adverse Benefit Determination that includes the following information:

- For Health Care Claims:
  - The specific reason or reasons the Claim was denied, in whole or in part;
  - Reference to the specific Plan provisions on which the denial was based;
  - A description of any additional information that the Claimant must submit in support of his Claim and an explanation of why the additional information is needed;
  - An explanation of the Plan's Claim review procedures and applicable time limits;
  - Copy of any internal rule, guideline, protocol or similar criteria that was relied on, or the notice will include a statement that a copy is available at no cost, upon request, if relevant;
  - Copy of the scientific or clinical judgment, or the notice will include a statement that a copy of the scientific or clinical judgment is available at no cost, upon request; and
  - A statement of the Claimant's rights under ERISA to bring a civil action and the applicable deadlines.
- For Health Care Claims, except dental and vision:
  - Information sufficient to identify the Claim, including: Date of service; provider; Claim amount; the denial codes and their respective meanings: a description of any standard used in determining the denial; a provision stating that diagnosis and treatment codes and their corresponding meanings are available upon request without charge; and disclosure of the availability of, and contact information for, any applicable ombudsman established under the Affordable Care Act to assist individuals with the internal Claims and appeals and external review processes; and
  - Notice that the Claimant may request an external review with an independent review organization after the Plan's Claims procedures have been exhausted.
- For Short Term Disability Claims:
  - The specific reason or reasons the Claim was denied, including a discussion of the decision and, if applicable, an explanation of the basis for disagreeing with or not following:
    - » The views of a health care or vocational professional who treated or evaluated the Employee;

    - » The views of a medical or vocational expert whose advice was solicited by the Plan in connection with the claim; or
    - » A disability determination made by the Social Security Administration;
  - Reference to the specific Plan provisions on which the denial was based;
  - A description of any additional information that the Claimant must submit in support of the Claim and an explanation of why the additional information is needed;
  - An explanation of the Plan's Claim review procedures and applicable time limits;
  - Copies of any internal rule, guideline, protocol or similar criteria relied on, or a statement that no such rule, guideline, protocol or similar criteria exists;
  - Copy of the scientific or clinical judgment, or a statement that a copy of the scientific or clinical judgment is available at no cost, upon request;
  - A statement that the Claimant is entitled to receive reasonable access to, and copies of, all documents, records and other information relevant to the Claim upon request, free of charge; and
  - A statement of the Claimant's rights under ERISA section 502(a) to bring a civil action and the applicable deadlines.
- For Other Benefit Claims:
  - The specific reason or reasons the Claim was denied;
  - Reference to the specific Plan provisions on which the denial was based;
  - A description of any additional information that the Claimant or the Claimant's designated beneficiary will need to submit in support of the Claim and an explanation of why the additional information is needed;
  - An explanation of the Plan's Claim review procedures and applicable time limits; and
  - A statement of the Claimant's rights under ERISA section 502(a) to bring a civil action, and the applicable deadlines.

Adverse Benefit Determination Appeals

A Claimant has the right to appeal certain denied claims, as described for each Claim type in the sections that follow.

Health Care Claims

An Adverse Benefit Determination is:

- A denial, reduction, or termination of a benefit, or failure to provide or make payment in whole or in part for a benefit; or
- Rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time. A rescission of coverage, as described more fully on page 105, is a cancellation or discontinuation of coverage that has a retroactive effect, except to the extent it is attributable to a failure to pay required premiums or contributions in a timely manner, or other events (such as fraud).

The Explanation of Benefits (EOB) that the Claimant will receive serves as the notice of an Adverse Benefit Determination for a Health Care Claim.

- All appeals must be in writing on the forms required by the applicable Claims Fiduciary and addressed to the applicable Claims Fiduciary. The forms must include your signature or the signature of your spouse or Authorized Personal Representative.
  - A written appeal should include evidence or specific facts and Plan provisions that support a Claim for benefits. Submit a completed Appeal Form and any additional information to substantiate the appeal to the applicable Claims Fiduciary.

  - An appeal must contain all of the information listed on page 67 as well as any denial codes and corresponding meanings. An appeal for Claims from an applicable third-party Claims Fiduciary must contain all of the information required by the applicable Claims Fiduciary on the forms required by such Claims Fiduciary.
- Only the Claimant or his Authorized Personal Representative has the right to appeal a Claim for benefits that was denied in whole or in part. General inquiries for information on whether a certain medical procedure, prescription, Treatment Plan or other similar request is covered by the Plan are not considered a Claim for benefits.
- If a post-service Claim has been denied, in whole or in part, the Claimant or his Authorized Personal Representative have no more than 180 days after the receipt of an Adverse Benefit Determination to file an appeal.
- Upon appeal, the Claimant has the right to:
  - Designate an Authorized Personal Representative (who may be an attorney);
  - Submit additional material, including comments, statements, or documents; and
  - Be advised of the identity of any medical expert.
- Upon appeal of all health care claims **except** dental and vision, the Claimant or their Authorized Personal Representative also has the right to receive copies, free of charge, of all new or additional evidence considered, relied upon or generated by the Plan or the Trustees, or any new or additional rationale relied upon in connection with the Claim. Such new or additional evidence or rationale shall be provided as soon as possible and sufficiently in advance of the Trustees' final decision in order to give the Claimant a reasonable opportunity to respond. If the new or additional evidence is received so late that the Claimant will not have a reasonable opportunity to respond within the prescribed time frame, the time period for the Claims Fiduciary to issue a decision will be tolled until the Claimant has an opportunity to respond. After the Claimant responds, or fails to respond, the Claims Fiduciary will issue its decision as soon as reasonably practicable.
- Preliminary Review: For post-service Health Care Claims, enrollment, premium payments and eligibility Claims for which the Board of Trustees is the Claims Fiduciary, the Fund Office will complete a preliminary review of the request within five business days of the Fund's receipt of the request for an appeal to determine if:
  - The Claimant was eligible 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;
  - The Adverse Benefit Determination relates to the Claimant's failure to meet the requirements for enrollment, premium payments or eligibility under the terms of the Plan; and
  - The Claimant has completed and provided all of the required information and forms to process the appeal.

If the additional information provided in the course of an Appeal is found to clearly fall within the guidelines and protocols for claim payment, the Claim will be reconsidered. The Claimant will receive a new EOB showing the additional benefits paid. In the case of an enrollment, premium payments or eligibility reversal, coverage will be updated to cover any additional period of eligibility supported by the additional information provided, the Claimant will be notified of the extension and Claims denied for that period will be reopened and reconsidered.

- Review of Appeals by the ***Appeals Committee*** of the Board of Trustees: Properly filed appeals for post-service Health Care Claims and enrollment, premium payments or eligibility Claims for which the Board of Trustees is the Claims Fiduciary will be reviewed at the next regularly scheduled appeals meeting of the Trustees, who meet at least quarterly. However, if the request for review is received within thirty days of the next regular meeting, the request for review will be considered at

the second regularly scheduled meeting following receipt of the request. If special circumstances require a further extension of time for processing, a determination will be made at the third regularly scheduled meeting following receipt of the request for review. Prior to the start of the extension, the Claimant will be advised in writing in advance if this extension will be necessary and will be notified of the special circumstances and the date by which a determination will be made. Once the decision has been made, the Trustees will mail their decision to the Claimant within five business days after making the determination. The Trustees' determination on review is binding on all parties.

- Review of Appeals where the Claims Fiduciary is a Third Party: The designated Claims Fiduciary will review the Claims appeal and provide its written decision to the Claimant within 60 days of receiving the appeal. The Claimant will receive written notice of the decision within 30 days after the appeal was received if the Claims Fiduciary has two levels of appeal.
- The Claimant has the right to access and copy (free of charge) all documents, records and other information relevant to his appeal. The Claimant also has the right to bring a civil action suit under Section 502 (A) of ERISA. Any such civil action must commence within 12 months following the date of determination letter.

Short Term Disability Claims

An Adverse Benefit Determination is:

- A denial, reduction, a termination of a benefit, or failure to provide or make a payment in whole or in part for a benefit; or
- A rescission of coverage. For this purpose, a rescission of coverage is any cancellation or discontinuance of Plan coverage for Short Term Disability benefits that has a retroactive effect, except to the extent it is attributable to a failure to pay required premiums or contributions in a timely manner toward the cost of Plan coverage.

The Board of Trustees is the Claims Fiduciary for Short Term Disability benefits. The Trustees will send the Claimant a written notice of the Adverse Benefit Determination for a Short Term Disability Claim.

- All appeals must be in writing, on the form required by the Fund. The forms must include your signature or the signature of the Authorized Personal Representative.
- A written appeal should include evidence or specific facts and Plan provisions that support a Claim for benefits. Submit a completed Appeal Form and any additional information to substantiate the appeal to the Fund Office.
- Only the Claimant or the Authorized Personal Representative have the right to appeal a Claim for benefits that was denied in whole or in part. General inquiries for information on whether the Claimant qualifies for Short Term Disability benefits are not considered a Claim for benefits.
- If a Claim for Short Term Disability benefits has been denied, in whole or in part, you have no more than 180 days after the receipt of an Adverse Benefit Determination to file an appeal.
- Upon appeal, the Claimant has the right to:
  - Designate an Authorized Personal Representative (who may be an attorney);
  - Submit new or additional evidence, including specific facts, statements, or documents;
  - Be advised of the identity of any medical expert; and
  - Receive copies, free of charge, of all new or additional evidence considered, relied upon or generated by the Plan or the Trustees; or any new or additional rationale relied upon in connection with the Claim.
  - Such new or additional evidence or rationale shall be provided as soon as possible and sufficiently in advance of the Trustees' final decision in order to give the Claimant a reasonable opportunity to respond.

- Preliminary Review: The Fund Office will complete a preliminary review of a Claim request within five business days of the Fund's receipt of the request for an appeal to determine if:
  - The Claimant was eligible for Short Term Disability benefits under the Plan;
  - The Adverse Benefit Determination relates to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan; and
  - The Claimant has completed and provided all of the required information and forms to process the appeal.
- If the additional information provided in the course of an appeal is found to clearly fall within the guidelines and protocols for Claim payment, additional weekly benefits and/or credit of hours will be processed on the next following weekly payment cycle for any retroactive time that is approved based on the new information.
- In the case of an eligibility reversal, coverage will be updated to cover any additional period of eligibility supported by the additional information provided, and the Claimant will be notified of the extension and Claims denied for that period will be reopened and reconsidered.
- Review of Claim Appeals by the Appeals Committee of the Board of Trustees: Properly filed appeals will be reviewed at the next regularly scheduled appeals meeting of the Trustees, who meet at least quarterly. However, if the request for review is received within thirty days of the next regular meeting, the request for review will be considered at the second regularly scheduled meeting following receipt of the request. If special circumstances require a further extension of time for processing, a determination will be made at the third regularly scheduled meeting following receipt of the request for review. Prior to the start of the extension, the Claimant or the Authorized Personal Representative will be advised in writing in advance if this extension will be necessary and will be notified of the special circumstances and the date by which a determination will be made. Once the decision has been made, the Trustees will provide their decision to the Claimant or the Authorized Personal Representative within five business days after making the determination. The Trustees' determination on review is binding on all parties.
- The Claimant has the right to access and copy (free of charge) all documents, records and other information relevant to the appeal. The Claimant also has the right to bring a civil action suit under Section 502 (A) of the Employee Retirement Income Security Act (ERISA). Any such civil action must commence within 12 months following the date of determination letter.

Other Benefit Claims

An Adverse Benefit Determination is a denial, reduction, or termination of a benefit, or failure to provide or make payment in whole or in part for a benefit.

- All appeals regarding Other Benefit Claims, which include Maternity Leave, Vacation Savings Plan benefits, Life Insurance benefits and Accidental Death and Dismemberment benefits, must be in writing on the forms required by the applicable Claims Fiduciary and addressed to the applicable Claims Fiduciary. The forms must contain the Claimant's signature or the signature of the Authorized Personal Representative.
- The written appeal should include evidence or specific facts and Plan provisions that support a Claim for benefits, and all of the information required by the applicable Claims Fiduciary. Submit a completed Appeal Form and any additional information to substantiate the appeal to the applicable Claims Fiduciary.
- Only the Claimant, the Authorized Personal Representative or, if applicable, the designated beneficiary has the right to appeal a Claim for benefits that was denied in whole or in part. General inquiries for information on whether the Claimant qualifies for benefits under the insured program are not considered a Claim for benefits.

- If a Claim has been denied, in whole or in part, the Claimant, the Authorized Personal Representative or, if applicable, the designated beneficiary has no more than 90 days after receipt of an Adverse Benefit Determination on appeal.
- Upon appeal, the Claimant or, if applicable, the designated beneficiary has the right to:
  - Designate an Authorized Personal Representative (who may be an attorney); and/or
  - Submit additional material, including comments, statements, or documents.
- Review of Appeals: The Claims Fiduciary will review the Claim appeal and provide its written decision within 60 days of receiving the appeal. In some instances, the Claimant or, if applicable, the designated beneficiary will be notified in the original 60-day period that an extension is required and that the Claims Fiduciary will provide a written decision no later than 120 days after receiving the appeal.

Notice of Appeals Decision

When the Plan notifies a Claimant of its decision on a Claim on appeal, it will provide certain information, as described in the sections that follow.

For Health Care Claims

- The specific reason or reasons for its decision.
- Reference to the specific Plan provisions on which the determination was based.
- An explanation of the basis for the Adverse Benefit Determination.
- A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to the Claimant's Claim for benefits. Information is considered relevant if it:
  - Was relied upon by the Claims Fiduciary in making the decision;
  - Was submitted, considered, or generated regardless of whether it was relied upon; or
  - Demonstrates compliance with Claim processing requirements.
  - Relevant information includes but is not limited to:
    - » Relevant internal rules, guidelines, protocol or other similar criteria;
    - » Explanation of the scientific or clinical judgment that formed the basis of the Adverse Benefit Determination if the Claim is denied based on Medical Necessity, Experimental treatment or similar exclusion or limit; and
    - » The identity of any medical expert who provided a determination for a Claim.
- A statement describing any further appeal procedures offered by the Plan including the Claimant's right to obtain information about such procedures.
- Copy of any internal rule, guideline, protocol or similar criteria that was relied on, or a statement that a copy is available at no cost upon request, if relevant to a Claim.
- A statement that a copy of the scientific or clinical judgment is available at no cost, upon request, if relevant to a Claim that is denied due to a medical judgment which includes but is not limited to Medical Necessity, Experimental or Investigational treatment, or similar exclusion or limit.
- A statement that if the appeal is denied, the Claimant has the right to initiate a lawsuit under ERISA section 502(a). Any lawsuit must be initiated within 12 months of the denial on appeal.

For Health Care Claims, Except Dental and Vision

- Information sufficient to identify the Claim involved, including: date of service; provider; Claim amount; and any denial codes and their respective meanings; a description of any standard used to determine the denial; and a provision stating that diagnosis and treatment codes and their corresponding meanings are available upon request without charge.

- New or additional information considered, relied upon or generated during the appeal as well as any new or additional rationale for the denial, if any;
- For a Claim based on medical judgment or involving the balance billing protections of the No Surprises Act, to request an external review from an independent review organization after the Plan's Claims appeal procedures have been exhausted.
- Disclosure of the availability of, and contact information for, any applicable ombudsman established under the Affordable Care Act to assist individuals with the internal Claims and appeals and external review processes for Health Care Claims.

For Short Term Disability Claims

- The specific reason or reasons for its decision including a discussion of the decision, and, if applicable, an explanation of the basis for disagreeing with or not following:
  - The views of a health care or vocational professional who treated or evaluated the Claimant;
  - The views of a medical or vocational expert whose advice was solicited by the Plan in connection with the Claim; or
  - A disability determination made by the Social Security Administration.
- Reference to the specific Plan provisions on which the determination was based.
- An explanation of the basis for the Adverse Benefit Determination.
- A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to the Claim for benefits. Information is considered relevant if it:
  - Was relied upon by the Trustees in making the decision;
  - Was submitted, considered, or generated regardless of whether it was relied upon; or
  - Demonstrates compliance with Claim processing requirements.
  - Relevant information includes but is not limited to:
    - » New or additional information considered, relied upon or generated during the appeal as well as any new or additional rationale for the denial, if any;
    - » Relevant internal rules, guidelines, protocol or other similar criteria;
    - » Explanation of the scientific or clinical judgment that formed the basis of the Adverse Benefit Determination if the Claim is denied based on Medical Necessity, Experimental treatment or similar exclusion or limit; and
    - » The identity of any medical expert who provided a determination for a Claim.
- Copies of any internal rule, guideline, protocol or similar criteria relied on by the Trustees,
- or a statement that no such rule, guideline, protocol or similar criteria was considered.
- A statement that the Claimant may receive, free of charge, upon request, an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to the medical circumstances, if the Plan's decision is based on a Medical Necessity, Experimental treatment, or similar exclusion or limitation.
- A statement that if the appeal is denied, the Claimant has the right to initiate a lawsuit under ERISA section 502(a). Any lawsuit must be initiated within 12 months of the denial on appeal. The notice shall also include the calendar date by which the Claimant must initiate the lawsuit.

For Other Benefit Claims

- The specific reason or reasons for its decision.
- Reference to the specific Plan provisions on which the determination was based.
- An explanation of the basis for the Adverse Benefit Determination.

- A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to the Claim for benefits. Information is considered relevant if it:
  - Was relied upon by the Claims Fiduciary in making the decision;
  - Was submitted, considered, or generated regardless of whether it was relied upon; or
  - Demonstrates compliance with Claim processing requirements.
- A statement that if the appeal is denied, the Claimant has the right to initiate a lawsuit under ERISA section 502(a). Any lawsuit must be initiated within 12 months of the denial on appeal.

External Review of Health Care Claims

If an appealed Health Care Claim, **except** a dental or vision Claim, is denied by the Appeals Committee of the Board of Trustees or a third-party Claims Fiduciary, the Claimant may request further review by an independent review organization ("IRO"), as described below. External review does not apply to dental and vision Claims. Only denied Health Care Claims, other than dental or vision claims that involve medical judgment or the balance billing protections of the No Surprises Act and rescission claims, are eligible for external review.

Generally, a Claimant may request an external review only after exhausting the internal review and appeals process described above. If a Claim is denied due to failure to meet the requirements for eligibility and/or enrollment under the terms of the Plan, an external review is not available. The external review of Claims is intended to comply with applicable law and regulations and guidance as issued by the Department of Labor, Department of Health and Human Services and the Internal Revenue Service.

The external review process is as follows:

- A request for external review of a non-urgent Claim must be made, in writing, within four months of the date of the Explanation of Benefits (EOB) indicating an Adverse Benefit Determination or the date of the letter advising of an adverse appeal Claim benefit determination, whichever is later. The Plan's internal review and appeals process generally must be exhausted before an external review is available. External review of a Claim will only apply to an adverse benefit determination or final internal adverse benefit determination involving a medical judgment or the balance billing protections of the No Surprises Act.
- The Claims Fiduciary will complete a preliminary review of the request within five business days of the Claims Fiduciary's receipt of the external review request to determine whether the Claimant has:
  - Exhausted the Plan's internal Claims and appeals process (except in limited, exceptional circumstances); and
  - Completed the proper form to request an external review. Additional information is not required, as the information submitted for the earlier appeal of the denied claim is deemed complete. However, if additional information is available, it may be submitted for evaluation.

The Claims Fiduciary will notify the Claimant in writing within one business day of completing its preliminary review if the request meets the requirements for external review. If applicable, the notification will inform the Claimant that 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 (EBSA) (toll-free number 866-444-EBSA (3272)).

- If the request is complete and eligible, the Claims Fiduciary will assign the request to an IRO and provide, within five business days after the assignment to the IRO, documents and information it considered in making its Adverse Benefit Determination. The IRO is not eligible for any financial

incentive or payment based on the likelihood that it would support the denial of benefits. The Claims Fiduciary will rotate assignments among IROs with which it contracts.

- Once the Claim is assigned to an IRO, the following procedures will apply:
  - If additional information is needed, the assigned IRO will notify the Claimant in writing of how he may submit additional information regarding his Claim. The Claimant has 10 business days following receipt of notice from the IRO to submit the information.
  - If the Claimant submits additional information related to the Claim, the assigned IRO will, within one business day, forward that information to the Claims Fiduciary. Upon receipt of any such information, the Claims Fiduciary may reconsider its Adverse Benefit Determination that is the subject of the external review.
  - Reconsideration by the Claims Fiduciary will not delay the external review. However, if upon reconsideration, the Claims Fiduciary reverses its Adverse Benefit Determination, it will provide written notice of its decision to the Claimant and the IRO within one business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.
  - The IRO will review all information and documents received in a timely manner. In reaching a decision, the IRO will review the Claim as if it is new and will not be bound by any decisions or conclusions reached during the Claims Fiduciary's internal Claims and appeals process. However, the IRO will be bound to abide by the terms of the Plan to ensure that the decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must abide by the Plan's requirements for benefits, including:
    - » The Plan's standards for clinical review criteria;
    - » Medical Necessity;
    - » Industry standards or appropriateness;
    - » Health care setting; or
    - » Level of care 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 the Claimant's medical records;
    - » Any recommendations or other information from his treating health care providers;
    - » Any other information from the Claimant or the Claims Fiduciary;
    - » Reports from appropriate health care professionals;
    - » Appropriate practice guidelines; or
    - » The Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).
  - After the IRO receives the request for the external review, the assigned IRO will provide written notice of its final external review decision to the Claimant and the Claims Fiduciary within 45 days. The assigned IRO's decision notice will contain:
    - » 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; the health care provider; the Claim amount (if applicable); a statement that the diagnosis and treatment codes, and their corresponding meanings, are available upon request; and the reason for the previous denial.
    - » The date that the IRO received the assignment to conduct the external review and the date of the IRO decision.

    - » References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision.
    - » A discussion of the principal reason(s) for its decision, including the rationale for the decision and any evidence-based standards that were relied upon in making its decision; including a statement that the determination is binding except to the extent that other remedies may be available under applicable State or Federal law; a statement that judicial review may be available to the Claimant; and current contact information, including phone number, for the health insurance consumer assistance or ombudsman established under law to assist with external review processes.
- A Claimant may request an expedited external review if:
    - The Claimant receives an initial Adverse Benefit Determination that involves a medical condition for which the time frame for completion of an internal appeal would seriously jeopardize his life or health, or would jeopardize his ability to regain maximum function, and the Claimant has filed a request for an urgent care internal appeal; or
    - The Claimant receives an adverse appeal benefit determination that involves a medical condition for which the time frame for completion of a standard external review would seriously jeopardize his life or health or would jeopardize his ability to regain maximum function; or, he receives an adverse 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 has not yet been discharged from a facility.
      The process of the expedited external review will not differ from that explained on page 78, but the following time frames will apply.
        - » The Claims Fiduciary's preliminary review will be completed immediately.
        - » The Claims Fiduciary will immediately notify the Claimant whether the request meets the requirements for an external review.
        - » If requirements are met, the Claims Fiduciary will assign an IRO and provide the documents and information it considered in making its Adverse Benefit Determination to the IRO expeditiously.
        - » The IRO will provide a decision in accordance with the requirements in this section within 72 hours. If the notice is not in writing, the IRO must provide written confirmation of its decision within 48 hours of providing the notice.
- After external review:
    - If the final external review reverses the Claims Fiduciary's Adverse Benefit Determination, upon the Claims Fiduciary's receipt of notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed Claim.
    - If the final external review upholds the Claims Fiduciary's Adverse Benefit Determination, the Plan will uphold the denial of coverage or payment for the reviewed Claim. If the Claimant is dissatisfied with the external review determination, he may seek judicial review as permitted under ERISA section 502(a). Any lawsuit must be initiated within 12 months of the denial on appeal.

Powers of the Trustees, Claims Fiduciaries and Other Delegates

The Trustees, the Appeals Committee or their designated Claims Fiduciaries, have sole, full and discretionary authority to make final determinations regarding any claim for benefits, the interpretation of the Plan and all documents, rules, procedures and terms of the Plan, and any administrative rules adopted by the Claims Fiduciaries. It is the Trustees' intention that the decisions of the Trustees will be accorded judicial deference in any subsequent administrative or court proceeding, to the extent the decisions do not constitute an abuse

of discretion. Benefits will be paid under the Plan if the Trustees or their delegate Claims Fiduciaries decide, in their discretion, that the Claimant is entitled to them.

Exhaustion of Remedies

Generally, you must follow and completely exhaust the Plan's appeal procedures (including time limits) before you can file a lawsuit under ERISA or initiate proceedings before any administrative agency. If the Plan fails to adhere to all Claims and Claims appeal requirements, you are deemed to have exhausted the Claims appeal process and may seek an external review or file a lawsuit, unless the Plan's failure is minor. In the event you submit a Claim for review and the Claim is denied, any legal action must begin within 12 months of the date the Fund provides an adverse benefit appeal determination.

Facility of Claims Payment

In the event the Fund becomes aware that you have been deemed incompetent or incapable of executing a valid receipt and no guardian has been appointed, the Fund may pay any amount otherwise payable to you to your spouse or any other person or institution determined by the Fund to be equitably entitled to payment. Any payment in accordance with this provision discharges the Fund from any further obligation.

Right to Information in Claims and Appeals Process

You have the right to receive, upon written request, copies of all documents relevant to the decision made on your appeal. You may also submit a request in writing to receive the identification of medical or other experts whose advice was obtained for reviewing your appeal. Any and all disclosures will be made in accordance with Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Change in Dependent Status

If you have a change in status, you must notify the Health Benefits Department within 90 days to update your information. Changes in status include:

- Change of address;
- Marriage (you may also want to change your Life Insurance beneficiary);
- Changes in Dependent eligibility or if you have a baby, adopt a child or become a stepparent;
- Death of a Dependent spouse or child (you may also want to file a claim for Life Insurance benefits and/or change your beneficiary); and
- Adding or dropping other insurance coverage, including coverage with Medicare or Medicaid.

You must notify the Health Benefits Department within 60 days of the following events, in order to avoid forfeiting continuation of coverage rights under COBRA:

- A divorce or legal separation; or
- When your Dependent child no longer meets the Plan's definition of a Dependent.

You will be required to provide supporting documentation for the above changes. For more information on required documentation, see page 14.

Change of Home Address

You must immediately notify the Health Benefits Department of a change in your home address or that of your Dependents. You can update your address on the Member Portal, or you can contact the Health Benefits Department as described below.

You should provide an alternate address for a Dependent that permanently resides outside of your home so that Explanations of Benefits (EOBs) and other materials can be mailed directly to them.

- Contact the Health Benefits Department regarding any change of status:
    - By Phone: 312-787-9455.
      Service Representatives are available Monday−Friday, from 8:00 a.m. to 4:30 p.m. (CT).
    - Documents should be mailed or delivered to:
      Mid-America Carpenters Regional Council Health Fund - Attn: Health Benefits Department
      12 E. Erie Street, Chicago, IL 60611
    - By Email: submit@macbenefits.org

Change of Beneficiary

It is your responsibility to keep your Life Insurance beneficiary up to date and you may change your beneficiary at any time. It is especially recommended to change your beneficiary after a life event such as marriage, divorce, birth of a child or death of a previous beneficiary. If you divorce, any previous spousal beneficiary designation will no longer apply. If you still want your former spouse as your beneficiary, you must complete a new form after the divorce is finalized.

Simply download and complete a Beneficiary Designation Form from the Fund's website at ***carpenterbenefits.org*** or call the Health Benefits Department and request that a form be mailed to you. Beneficiary Designation Forms can be sent to the Health Benefits Department as described above or can be submitted on the Member Portal for Fund Office review.

Your beneficiary designation does not become effective until the properly completed form is received by the Health Benefits Department

Special Enrollment

If you did not enroll yourself and/or any Dependent (including a spouse) when you and/or your Dependent first became eligible for coverage under the Plan because you had other coverage, you may enroll in this Plan through a special enrollment period, as shown below.

Reason for Becoming Eligible for Plan Coverage	You May Enroll in the Plan Within
Other group health plan or health insurance policy terminates	31 days after the termination of coverage
Medicaid or Children's Health Insurance Program (CHIP) coverage terminates	90 days after termination of coverage
You become eligible for financial assistance through Medicaid or CHIP designed to help you pay for Plan coverage	90 days after becoming eligible for financial assistance

Qualified Medical Child Support Orders (QMCSOs)

A Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice, as defined under ERISA, means a court order requiring a medical plan to provide medical benefits to the children of parents seeking divorce or other state domestic relations actions where financial support of children is involved.

A child covered under a QMCSO or a National Medical Support Notice will be enrolled as a Dependent under the coverage option in which you are enrolled. The Plan will not terminate an eligible Dependent child's coverage when the child is covered by a QMCSO.

Contact the Health Benefits Department at 312-787-9455 to request a copy of the Plan's QMCSO procedures free of charge or visit the Fund's website at ***carpenterbenefits.org***.

When Coverage Ends

This section discusses the circumstances in which your coverage or your Dependents' coverage under the Active Plan is terminated, and the available options for continuing coverage.

Your eligibility for Active Plan benefits will terminate on the last day of the second calendar month immediately following any Calendar Quarter in which you do not meet either of these two requirements:

- You do not have Contributions of at least 300 hours (200 hours if an apprentice) paid on your behalf by Contributing Employers during the Calendar Quarter, and/or sufficient credit of hours under the Short-Term Disability benefit, to meet the respective 250- or 200-hour requirement; or
- You do not have Contributions of at least 1,200 hours (960 hours if an apprentice) paid on your behalf by Contributing Employers during the current Calendar Quarter and the three immediately preceding consecutive Calendar Quarters, and/or sufficient credit of hours under the Short Term Disability benefit, to meet the respective 1,000- or 760-hour requirement.

Participants Covered Under Participation Agreements

If you are covered under a Participation Agreement that provides eligibility on a month-to-month basis, your coverage will terminate in accordance with the terms of the applicable Participation Agreement, including termination of coverage upon the cessation of employment or any other event specified in that Agreement. In addition, your eligibility for Active Plan benefits will terminate on the:

- Last day of the month in which you enter the Military Service, to the extent permitted by law;
- Last day of the Coverage Quarter in which you are dropped from the Apprentice Program, only if you are covered by apprentice reduced coverage; or
- Date the Plan is discontinued.

Your Dependent's eligibility will terminate:

- When you no longer meet the eligibility requirements under the Plan;
- If you fail to provide the required documentation to verify Dependent status;
- Upon your Dependent's death; or
- When your Dependent no longer meets the Plan's definition of a Dependent, as described on page 12.

If a Dependent's eligibility terminates, coverage will end as follows:

- Spouse, as of the last day of the month of the effective date of your divorce or legal separation (you must provide a complete copy of the divorce decree);
- Dependent child, as of the last day of the month in which the child attains age 26 unless the child is disabled and satisfies the requirements, as described on page 12;
- Newborn child, 90 days after the date of the child's birth if the required documentation is not received (coverage will be reinstated effective on the date the Health Benefits Department receives all the required documentation);
- Stepchild, as of the last day of the month in which the Employee divorces or legally separates from the stepchild's parent (you must provide a complete copy of the divorce decree) or the stepchild's parent dies;
- Dependent spouse who enters Military Service, as of the last day of the month in which he enters Military Service, to the extent permitted by law;
- When a Dependent child becomes an eligible Employee under this Plan, to the extent permitted by law; or
- When a Dependent child becomes a Dependent spouse of another Covered Individual.

In the event you gain eligibility as an apprentice while still an eligible Dependent of another Participant of the Plan, you may elect to remain covered as a Dependent and forgo coverage as an apprentice. Your election must be in writing, using the forms provided by the Fund Office. Contact the Health Benefits Department, at 312-787-9455, for more information.

When your eligibility for coverage under the Active Plan ends due to a reduction in hours worked or a qualifying life event, you have options for continuing coverage in the Health Fund, as described in this section. Based on your individual circumstances, and as long as you elect coverage and pay the Premium Payment on or before the due date, you may be able to continue coverage with one of these options:

- Active Plan coverage through Self-Payment of Hours;
- Active Plan coverage under COBRA; or
- Low Cost Medical Plan coverage.

See pages 92-94 for information on additional continuation-of-coverage options, including coverage if you serve in the Military Service or take a leave under the Family and Medical Leave Act.

In addition, coverage will end on the first day of the month for which a Premium Payment is required for continuation coverage but is not received by the Health Benefits Department on a timely basis.

Self-Payment of Hours

If you have failed to meet the Plan's eligibility requirements due to a reduction in hours, you are eligible to elect Self-Payment of Hours. This option enables you to continue your coverage under the Active Plan if you meet the following criteria:

- You were eligible for benefits during the preceding Coverage Quarter (including a previously self-paid Coverage Quarter);
- You are a Member in Good Standing with your local Union (your dues must be current and not in arrears), and if you are an apprentice, you must be currently enrolled in the Apprentice Program; and
- You have not already exhausted the maximum number of Coverage Quarters through Self- Payment of Hours.
- Dropped apprentices are not eligible for Self- Payment of Hours.
- Retirees are not eligible for Self-Payment of Hours.

Continuing Coverage with Self-Payment of Hours

To continue coverage through Self-Payment of Hours, you must make a single quarterly payment for the number of hours you need to either meet the 250 hour (200 hours for apprentice) quarterly requirement, or the 1,000 hour lookback (760 hours for apprentice) from the current and three immediately preceding Calendar Quarters (whichever is less).

The Premium Payment amount you must pay is calculated to be the lesser of:

- The difference between 300 hours (200 hours for apprentice reduced coverage) and the number of hours contributed on your behalf in the current Calendar Quarter, multiplied by the current Contribution rate; or
- The difference between 1,2000 hours (960 hours for apprentice reduced coverage) and the number of hours contributed on your behalf in the current and three immediately preceding Calendar Quarters, multiplied by the current Contribution rate.

The current Contribution rate is determined in accordance with the terms of the Commercial Area Agreement for Cook, Lake and DuPage Counties between the Mid-America Regional Bargaining Association ("MARBA") and the Union, the collective bargaining agreement between the Residential Construction Employers Council and the Union or such other Contribution rate that the Trustees may adopt from time to time.

Other Important Information About Self-Payment of Hours

- You may self-pay for a maximum of 300 hours per Calendar Quarter; however, you may only self-pay for a maximum of four Coverage Quarters in a rolling 12 Calendar Quarter (three year) period.
- Self-Payment of Hours does not count toward meeting future eligibility requirements. Only employer Contributions for the hours you worked and hours credited for a Short Term Disability Claim count toward calculating future eligibility.
- Coverage provided through self-pay runs concurrently with the maximum amount of coverage months provided under COBRA; this means that your total months of potential COBRA eligibility are reduced by the number of months of coverage you receive by making Self-Payments of Hours.
- Self-Payment of Hours cannot be used to establish initial eligibility.
- Self-Payment of Hours may only be elected by active Participants. It is not available to retirees and cannot be independently elected by a Dependent.
- Apprentices that qualify for Self-Payment of Hours will be offered the opportunity to continue coverage under the same level of benefits they lost; either full active coverage or reduced apprentice coverage.

Making Payments

Self-Payment of Hours requires that you make one Premium Payment to cover the entire Coverage Quarter. The first payment is due on the first day of the Coverage Quarter. The Plan allows for a 30 day grace period, or the last day of the first month in the Coverage Quarter, whichever is later. Payments made after the grace period will not be accepted and coverage will not be reinstated.

Payment by check or money order should be made payable to Mid-America Carpenters Regional Council Health Fund. Please include your identification number (as found on your BCBS ID card) on your check or money order. You will not receive an invoice, and you are responsible for remitting your Premium Payment on a timely basis.

Send your Election Form and Premium Payment to the Fund Office:

Mid-America Carpenters Regional Council Health Fund
Attn: Continuation Coverage
12 E. Erie Street
Chicago, IL 60611

Coverage Quarter	Payment Due Date	Last Day Payment Will Be Accepted
Dec. 1st – Feb. 28th/29th	Dec. 1st	Dec. 31st
Mar. 1st – May 31st	Mar. 1st	Mar. 31st
June 1st – Aug. 31st	June 1st	June 30th
Sept. 1st – Nov. 30th	Sept. 1st	Sept. 30th

Continuation Coverage under COBRA

The Fund provides health care continuation coverage under COBRA for qualified beneficiaries whose coverage under the Plan would otherwise end because of your termination of employment, death or certain other qualifying events. If you and/or your qualified beneficiary's coverage under the Plan terminates, you or your qualified beneficiary may choose to pay for and receive full or limited health coverage under the Active Plan. Continuation coverage under COBRA does not include Short Term Disability, Life Insurance or AD&D Insurance coverage.

Options for Continuation Coverage under COBRA for Active Plan Participants

- **Core Plus Coverage**: Includes comprehensive medical, HRA, prescription drug, dental and vision benefits; or
- **Core Limited Coverage**: Includes comprehensive medical, HRA and prescription drug benefits.

Apprentice Plan Participants eligible for continuation coverage under COBRA may choose apprentice reduced coverage, which continues medical and vision benefits. This coverage does not include prescription drug and dental benefits.

A qualified beneficiary under the Plan means you, your spouse (or your former spouse, legally separated spouse or surviving spouse) or your Dependent who is covered under the Active Plan upon termination of coverage under the Active Plan, subject to the Plan receiving timely notice of the loss of coverage (where notice is required).

A new spouse or Dependent child born to you, adopted by you or placed for adoption with you during your period of Continuation Coverage under COBRA is also considered a qualified beneficiary. You must provide documentation verifying the marriage, birth, adoption or placement of a child with you for adoption to have this Dependent added to your Continuation Coverage under COBRA.

One or more of the qualifying events listed below entitles you and/or your qualified beneficiaries to elect Continuation Coverage under COBRA:

- Termination of your employment (for causes other than gross misconduct);
- Reduction in your work hours;
- Your death;
- You and your spouse becoming legally separated or divorced;
- Your child loses Dependent status under the Plan; or
- You become entitled to, or eligible for and enroll in Medicare coverage (and your Dependents then lose Plan coverage).

COBRA coverage is offered for the continuation periods shown in the chart below.

Qualifying Event	Qualified Beneficiaries	Maximum Coverage Period	Continuation Coverage Options Available
Your termination of employment or a reduction in hours worked	You Your spouse Your Dependent child	18 months	COBRA, Low Cost Medical Plan or Self-Payment of Hours Note: You cannot elect the Low Cost Plan or the Self-Payment of Hours option if you are receiving a pension benefit.

Qualifying Event	Qualified Beneficiaries	Maximum Coverage Period	Continuation Coverage Options Available
Your death	Your spouse Your Dependent child	36 months	COBRA
Divorce or legal separation	Your spouse Your Dependent stepchild	36 months	COBRA
Your child no longer qualifies as a Dependent child under the Plan	Your Dependent child	36 months	COBRA

Disability Extension

If you or a covered Dependent enrolled in Continuation Coverage under COBRA, are subsequently determined by the Social Security Administration to be disabled and you notify the Fund Office, you and your covered Dependents may be entitled to receive up to an additional 11 months of Continuation Coverage under COBRA, for a total of 29 months. You must notify the Health Benefits Department at 312-787-9455 within 60 days of receiving the disability award notice from the Social Security Administration, and before the end of the 18-month COBRA coverage period.

Contact the Health Benefits Department at the Fund Office for more information regarding continuation coverage. You may reach a Service Representative Monday–Friday, from 8:00 a.m. to 4:30 p.m. (CT) at 312-787-9455.

General Rules

The Fund has developed notice and election procedures in accordance with COBRA as follows:

1. The Trustees will provide written notice of the provisions of Continuation Coverage under COBRA to you and your covered Dependents within 90 days of the date coverage under the Plan begins, or within 90 days of a significant change in procedures. Notice provided to the Participant will be deemed notice to all Dependents, unless the Fund has notice that your Dependent resides at a different address.
2. An Employer may notify the Fund if you lose coverage due to reduction in hours, termination of employment or death (but you or your covered Dependent should also call the Fund Office to report these events).
3. You or your covered Dependent is responsible for notifying the Fund and providing documentation within 60 days of divorce, legal separation or a Dependent no longer being eligible for coverage. If the Fund is not notified within 60 days of a qualifying event, your Dependent will lose eligibility for Continuation Coverage under COBRA.
4. Once you or your Employer notifies the Fund of a qualifying event, the Fund will send you a COBRA notice and enrollment form within 14 days.
5. You have a 60-day election period to complete and return the enrollment form to the Health Benefits Department. If you don't return the form within 60 days, you lose eligibility for Continuation Coverage under COBRA.
6. You may elect Continuation Coverage under COBRA for yourself and/or your eligible Dependents. If you decline coverage for yourself, your eligible Dependents may elect coverage independently from you.
7. Any qualified beneficiary who elects Continuation Coverage under COBRA must notify the Health Benefits Department within 14 days of becoming covered under another group health plan.
8. A qualified beneficiary may elect Continuation Coverage for his Dependents. However, each qualified beneficiary has an independent right to elect Continuation Coverage under COBRA.

Paying for Continuation Coverage under COBRA

The Fund Office will notify you of the cost of Continuation Coverage under COBRA when it notifies you of your right to continue coverage. The cost for Continuation Coverage under COBRA will be determined by the Trustees on an annual basis and will not exceed 102% of the cost to provide that coverage. The cost for extended Continuation Coverage under COBRA if you are disabled (from the 19th month through the 29th month) is an amount determined by the Trustees, not to exceed 150% of the cost to provide coverage.

Your first Premium Payment for Continuation Coverage under COBRA must include payments for any months retroactive to the day your coverage under the Active Plan ended. This

Premium Payment is due no later than 45 days after the date you signed the election form and returned it to the Fund Office.

Subsequent Premium Payments are due on the first business day of each month for which coverage is provided (due date). There is a grace period from the due date of the Premium Payment by which time the Premium Payment must be paid. Coverage will be provided as long as payment for that month is received by the Health Benefits Department no later than 30 days after the due date or, for months with 31 days, the last day of the month in which the Premium Payment is due.

However, if a monthly payment is paid later than the first day of the month, but before the end of the grace period, coverage will be suspended as of the first day of the monthly coverage period. Upon receipt by the Fund Office of the monthly Premium Payment, coverage will be retroactively reinstated going back to the first day of the month. Any Claim submitted for benefits while coverage is suspended will be denied by the Plan and must be resubmitted for payment once coverage is reinstated.

If payment is not received within the grace period, all benefits will end immediately. Once your Continuation Coverage under COBRA is terminated, it cannot be reinstated

Send your completed COBRA application and Premium to the Fund Office:

Mid-America Carpenters Regional Council Health Fund
Attn: Continuation Coverage 12 E. Erie Street
Chicago, IL 60611
Telephone: 312-787-9455

Electronic Payments

You can set up online payment for paying Premium Payments for Continuation Coverage under COBRA and the Low Cost Medical Plan. An additional convenience service fee will apply for checking, savings and credit card transactions. **You cannot set up a recurring monthly payment through the electronic system. Payment must be made each and every month.**
You must first create an electronic payment account through the Health Benefits Department. To do so, you must return your application for Continuation Coverage with the first month's Premium Payment via check or money order.

For qualified COBRA beneficiaries who individually elect "single" COBRA coverage, in lieu of "family" coverage, you must make a separate Premium Payment each month for each individual who elected "single" coverage.

Once you've established your account, you can follow the instructions on the Fund's website at ***carpenterbenefits.org*** to enter your COBRA/Low Cost ID number and access the electronic payment system. To assist the Health Benefits Department in processing your Premium Payment, you must specify the month(s) you're paying for in the applicable section on the website. You will receive a confirmation number once you have made your Premium Payment. Look for your confirmation email. Save this email for your records.

Regardless of your payment method, failure to timely submit your Premium Payment will result in cancellation of coverage.

Termination of Continuation Coverage under COBRA

The Fund will automatically terminate Continuation Coverage under COBRA in all instances permitted by the COBRA statute and its regulations, including if:

- You do not make timely Premium Payments under the Plan;
- You become covered under another health care plan that does not exclude coverage for pre-existing conditions that are covered by this Plan;
- You become entitled to, eligible for and enrolled in Medicare coverage; or
- The Trustees discontinue all coverage under the Plan.

It is the intent of the Trustees to provide Continuation Coverage under COBRA benefits in accordance with the federally required minimum benefits provisions of COBRA. The Fund has developed administrative guidelines and interpretive procedures to be used in complying with the continuation of benefits provisions of COBRA. To the extent that this or any administrative guidelines or interpretive procedures inadvertently conflict with COBRA, the applicable sections of COBRA will prevail.

Transferring Between Types of Continuation Coverage

If you are a COBRA qualified beneficiary (including Dependents), as described on page 83, and you elected Continuation Coverage under COBRA for the Active Plan following a loss of coverage related to the reduction of hours or termination of employment, you may elect to drop to a lower type of Continuation Coverage (less coverage), but only prospectively (not retroactively), as shown in the chart below.

What you currently have:	What options are available to transfer to:
COBRA Plus (Medical, Rx, Dental, Vision)	COBRA Core, Low-Cost
COBRA Core (Medical, Rx)	Low-Cost
Low-Cost	N/A
Self-Payment of Hours	COBRA, Low Cost

The option to change plans is available only once per COBRA qualifying event. Whenever you transfer from Continuation Coverage under COBRA to alternative coverage under the Low Cost Medical Plan, all former qualified beneficiaries effectively waive all existing and future Continuation Coverage under COBRA under the Active Plan for that qualifying event and, further, waive all COBRA rights under the Low Cost Medical

Plan for that qualifying event. You and any other qualified beneficiaries must also follow all election procedures for the Low Cost Medical Plan.

Combined coverage consisting of Continuation Coverage under COBRA in the Active Plan and alternative coverage under the Low Cost Medical Plan may not exceed the maximum period of 18 months from the date of the original qualifying event under the Active Plan for each qualified beneficiary electing alternative coverage under the Low Cost Medical Plan.

For information regarding coordination for Continuation Coverage under COBRA and Self-Payment of Hours, see pages 86-89.

Retirement

At retirement, you may be able to elect Continuation Coverage under COBRA, or if qualified, coverage under the Retiree Plan of Benefits. Health care benefits under the Retiree Plan are described in a separate booklet. Retirees are not eligible to elect Self-Payment of Hours or the Low Cost Medical Plan option.

For help about the retirement process and answers to any questions you may have about your benefits, contact the Retirement Benefits Department Monday– Friday, from 8:00 a.m. to 4:30 p.m. (CT) at 312-787-9455.

Low Cost Medical Plan

If you lose eligibility under the Active Plan, as an alternative to Continuation Coverage under COBRA, you may be able to elect to continue health coverage under the Low Cost Medical Plan. Coverage under the Low Cost Medical Plan may not exceed 18 consecutive months (18 months total when combined with prior continuation coverage under COBRA or Self- Payment of Hours) or 24 months of consecutive coverage under USERRA. Retirees or their Dependents are not eligible to elect the Low Cost Medical Plan.

Refer to the Schedule of Benefits on page 44 for the benefits provided under the Low Cost Medical Plan. Health coverage is subject to change as a result of Plan modifications.

If you lose Active Plan coverage, you may elect single or family coverage under the Low Cost Medical Plan to cover yourself, or you and your eligible Dependents, provided you pay the required monthly Premium Payment on time. Dependents cannot independently elect coverage under the Low Cost Medical Plan.

The amount of the monthly Premium Payment is determined by resolution adopted by the Trustees from time to time. No claims will be paid under the Low Cost Medical Plan until your Premium Payment is received by the Health Benefits Department.

For you and your eligible Dependent(s) to be covered under the Low Cost Medical Plan, you and your eligible Dependent(s) must waive all your rights to Continuation Coverage under COBRA.

Paying Your Monthly Premium

Your first monthly Premium Payment for the Low Cost Medical Plan coverage must be received by the last day of the month immediately after the last day of eligibility.
Subsequent monthly Premiums Payments are due on the first business day of each month for which coverage is provided. There is a grace period from the date the Premium Payment must be paid.

Coverage will be provided as long as payment for that month is received by the Health Benefits Department no later than 30 days after the due date or, for months with 31 days, the last day of the month in which the Premium Payment is due. However, if a monthly payment is paid later than the first day of the month, but before the end of the grace period, coverage will be suspended as of the first day of the monthly coverage period. Upon receipt by the Health Benefits Department of the monthly Premium Payment before the end of the grace period, coverage will be retroactively reinstated going back to the first day of the month. Any Claim submitted for benefits while coverage is suspended will be denied by the Plan and must be resubmitted for payment once coverage is reinstated.

Send your completed application and Premium Payment to the Fund Office:

Mid-America Carpenters Regional Council Health Fund Attn: Continuation of Coverage
12 E. Erie Street
Chicago, IL 60611
Telephone: 312-787-9455

Subsequent Premium Payments may be mailed to the above address, or you can set up an electronic payment as described in Electronic Payments on page 89.

When Low Cost Medical Plan Coverage Terminates

Coverage will end at the earliest of the following:

- When Premium Payments are not paid on a timely basis;
- When 18 consecutive months of coverage have elapsed (18 months total when combined with prior Continuation Coverage under COBRA or Self-Payment of Hours, or 24 months of consecutive coverage for USERRA coverage);
- When the Fund ceases to maintain any group health care coverage; or
- When the Low Cost Medical Plan is terminated. Once coverage ends, you may not elect the Low Cost Medical Plan again unless your Active Plan coverage is reinstated and you again lose eligibility for the Active Plan of benefits.

The Low Cost Medical Plan does not cover:

- Any Hospital and medical expenses that the Active Plan does not cover;
- Certain medical expenses as specifically indicated in the How Certain Services Are Covered under Comprehensive Medical Benefits section;
- Hearing care;
- Vision benefits;
- Dental benefits;
- Short Term Disability benefits; and
- AD&D Insurance benefits.

Continuation of Group Health Coverage under USERRA

Your benefits under the Plan end when you are deployed; however, when you return you are eligible for continuation of coverage. Upon returning from the Military Service, you may be able to continue health coverage (medical, prescription drug, dental and vision benefits, as applicable) under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended.

Continuation coverage under USERRA will continue until the earlier of:

- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or
- 24 consecutive months after your regular Plan coverage ends.

To continue coverage, you must elect Continuation Coverage under COBRA or the Low Cost Medical Plan and pay for it, as described on page 87 and page 91 respectively. If you go into active Military Service for less than 31 days, your coverage will be continued at the rate you were paying for coverage prior to your military leave.

However, in the event of a conflict between the provisions of continuation coverage under USERRA and COBRA, if you are eligible to continue coverage under both provisions, you will be entitled to the more generous coverage provisions of USERRA or COBRA. Continuation coverage under USERRA and COBRA will run concurrently. The administrative procedures with regard to notice, election and payment for Continuation Coverage under COBRA apply to continuation coverage under USERRA.

When Continuation Coverage under USERRA Ends

Continuation coverage under USERRA may end sooner than described above for any of the following reasons:

- You lose your rights under USERRA, such as for a dishonorable discharge;
- You fail to pay the premium for continuation coverage under USERRA;
- The Plan ceases providing group health plan coverage; or
- You fail to return to work or apply for reemployment within the time required under USERRA.

In the event that health coverage is continued under any other continuation provision of the Plan, the periods of continued coverage will run concurrently. If another continuation provision provides a shorter continuation period for which the premium is paid in whole or in part by an Employer, then the premium you are required to pay may increase for the remainder of the period provided above.

Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid leave during any 12-month period due to:

- Birth, adoption or placement of a child with you for foster care or adoption;
- Care of a seriously ill spouse, parent or child;
- Your serious illness; or
- A qualifying urgent need to leave because your spouse, son, daughter or parent has been notified of an impending call or order to active duty in the U.S. armed services in support of a military operation.

During your leave, you will maintain all the coverage offered through the Fund, to the extent the Plan receives Contributions from the Employer for time you spend on a leave under FMLA. You are eligible for a leave under FMLA if you:

- Have worked for a Contributing Employer for at least 12 months;
- Have worked at least 1,250 hours over the previous 12 months; and
- Work at a location where at least 50 Employees are employed by the Employer within 75 miles.

The amount of monthly Employer Contributions required to continue your current level of coverage while on a leave under FMLA will be determined using the average monthly hours you worked during the 12-month period preceding the month in which you begin a leave under FMLA.

Certain Employees are also allowed to take up to 26 weeks of unpaid leave during any 12-month period to care for a service member who is the son, daughter, parent, or next of kin of the Employee. The service member must be undergoing medical treatment, recuperation, or therapy for a serious illness or injury incurred in the line of duty while in the military or is otherwise in outpatient status or on the temporary disability retired list of the armed services.

The Fund will maintain your prior eligibility status until the end of your leave under FMLA, provided the Contributing Employer properly grants the leave under federal law and the Contributing Employer makes the required notification and payments to the Fund.

The Fund Office requires satisfactory proof of your Employer's approval of your leave under FMLA. If you and your Contributing Employer have a dispute regarding your eligibility and coverage under FMLA, the Fund will have no direct role in resolving such dispute, and your benefits may be suspended pending resolution of the dispute.

Extension of Coverage under the Active Plan of Benefits for a Work-Related Accidental Death

If an Employee dies in a Work-Related Accident while eligible for Plan benefits, his eligible Dependents will maintain comprehensive medical, dental, prescription drug and vision coverage through the date his active coverage would have terminated. Additionally, his eligible Dependents will continue eligibility, free of charge, from the point his coverage would have terminated for an additional five years. An eligible family member can contact the Heath Benefits Department at 312-787-9455 to discuss this coverage option.

Other Continuation Coverage Options —Health Insurance Marketplace

In addition to Continuation Coverage under COBRA, there may be other less expensive coverage options for you and your family if you lose coverage under the Plan. You may be able to buy coverage through the Health Insurance Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days after losing other health insurance.

Coordination of Benefits

If you and/or your Dependents are covered for health care under more than one health plan, this Plan will coordinate benefits with another plan, which means that the total payment from all plans will not exceed 100% of Covered Expenses.

"Another plan" means any of the following, whether insured or uninsured, that provide benefits or services for Hospital, medical, Behavioral Health and Substance Use Disorders, prescription drug, hearing, or dental care treatment:

- Group insurance coverage other than school accident-type coverage;
- Group subscriber contracts;
- Coverage through HMOs and other prepayment, group practice and individual practice plans;
- The medical benefits coverage in group, group-type and individual automobile "no fault" and traditional automobile "fault" type contracts;

- A governmental plan, including Medicare as provided for under the Social Security Act and coverage required or provided by law (such as through the Veterans Administration) but not Medicaid; or
- Individual insurance policies.

This Plan will follow the general Coordination of Benefits (COB) rules that apply throughout the insurance industry. Under COB rules, one plan has "primary" responsibility and is called the primary plan. The primary plan pays benefits first. When a plan pays second, it is called the secondary plan. When there is a third payer, it is called the tertiary plan. This Plan will follow COB rules as follows:

- The plan that covers you as participant is primary. (This applies to eligible Dependents, too. If a Dependent has coverage through his employer, that plan will be his primary plan.)
- If you are married, you and your spouse both work for different employers who offer health coverage, and you have a child eligible for Dependent coverage, the plan of the parent whose birthday (month and day) falls first in the Calendar Year will be the primary plan. If both parents have the same birthday, the plan covering the parent for the longer period of time will be the primary plan.
- If you are covered as a participant under more than one plan, the plan that has been in effect for you the longest will be the primary plan.
- If you are covered as a participant under another group plan and the other group plan contains a provision which excludes you from eligibility due to your coverage under this Plan; shifts coverage liability to this Plan to avoid any liability or to avoid the customary operation of this Plan's COB rules; or modifies, limits, or reduces your benefits because of your coverage under this Plan; this Plan considers such provision(s) to have no effect. As a result, this Plan coordinates benefits payable under this Plan with benefits that would have been payable under the other group plan (as if such provision had not existed).

When the Plan's Coordination of Benefits rules do not determine which plan pays first, the Plan will follow the industry standard rule that the plan that has covered the person for the longer period of time is the primary plan. The other plan will pay as secondary.

Coverage of Dependent Children in Divorce Situations: If the parents of a Dependent child are divorced or legally separated, a divorce decree or court order must be furnished to the Plan to ensure proper Coordination of Benefits. The plan of the parent who has responsibility for providing medical insurance for that Dependent as determined by the court order or divorce decree will be primary. See the Qualified Medical Child Support Orders section on page 83.

If there is no court order or divorce decree establishing responsibility for providing medical insurance, the plan covering the custodial parent will be the primary plan, the plan covering the spouse of the custodial parent will be secondary, the plan covering the non-custodial parent third and the plan covering the spouse of the non- custodial parent will be last.

Primary coverage by this Plan for stepchildren is provided only in the event that no other person is obligated to provide insurance and no other insurance is available through the biological or adoptive parents' employment. Coverage for stepchildren terminates the last day of the month of the divorce or legal separation.

If your Dependent spouse has other group insurance coverage available at no cost through their employer, this Plan will coordinate with the other plan on the same basis as if the Dependent spouse had elected such coverage.

Insurance for an Adult Dependent Child: If an adult Dependent child under the age of 26 has insurance coverage through his employer, the adult Dependent child's employer plan will pay first and this Plan will pay second.

HMO and POS Coverage Not Used: If your Dependent's primary coverage is a Health Maintenance Organization (HMO) or a Point of Service (POS) and he does not use the HMO or the POS services, no benefits will be paid by this Plan.

Services Provided by the Veterans Administration: The Veterans Administration (VA) is secondary to the Plan when a participant receives treatment at a VA facility for an Illness or Injury not related to Military Service.

Medicare: Health benefits under the Active Plan for Covered Individuals who are also eligible for Medicare will be paid as required by law. Generally, the Active Plan will be the primary plan and Medicare secondary, in all situations other than End-Stage Renal Disease (ESRD), in which case Medicare is primary after a 30-month coordination period, under most circumstances.

Medicaid: If you are covered under the Active Plan through your Employer, the Active Plan is primary to Medicaid.

Subrogation and Reimbursement

The subrogation and reimbursement provisions for the Fund are described below:

A. The Fund provides no benefits for Claims of a Covered Individual that are related to any Illness or Injury which is caused by third parties, or which is Work-Related or the responsibility of any other entity. The Fund will deny any Claim for an Illness or Injury which is caused by third parties, which is Work-Related or the responsibility of any other entity except as otherwise provided in this section on subrogation and reimbursement.

B. If the Fund chooses to advance benefits for the Injuries and Illnesses caused by third parties or that are Work-Related or the responsibility of any other entity, a Covered Individual:

1. Upon final adjudication, settlement and/ or receipt of case proceeds, agrees to reimburse the Fund up to
    i. the amount of benefits paid by this Fund or amounts that the Fund is obligated to pay as well as
    ii. any future benefits to be paid relating to the Illness or Injuries caused by the third party or for which a third party is responsible from any recovery received from any third party, insurer or any other source (including but not limited to persons, insurance carriers, estates, special trusts or other entities, hereinafter collectively referred to as "Source") or from any no-fault coverage, uninsured motorist coverage, underinsured motorist coverage, employers' Workers' Compensation insurance policies, personal injury protection coverage, medical payments coverage, financial responsibility, other insurance policies, funds or any other sources of recovery (hereinafter collectively referred to as "Coverage");
2. Agrees, without limiting what is stated in subsection (1) above, to allow the Fund to subrogate against or seek reimbursement with regard to any and all Claims, causes of action or rights that a Covered Individual has against any Source who has or who may have caused, contributed to or aggravated the Injuries or conditions for which a Covered Individual claims benefits from this Fund and to any Claims, causes of action or rights that a Covered Individual may have against any Coverage. The Covered Individual agrees to cooperate fully with the Fund in the prosecution of any Claims, causes of action or rights against any Source and/or Coverage;
3. Agrees to enter into a subrogation and reimbursement agreement (hereinafter collectively referred to as "Agreement") that is given to a Covered Individual by the Fund, which Agreement the Fund may require before a Covered Individual can receive any advancement of benefits (hereinafter collectively referred to as "Advance"). The Fund may withhold benefits until such Agreement is signed. If the Agreement is not executed by the Covered Individual(s), at the Fund's request, or if the Agreement is modified in any way without the consent of the Fund, the Fund may refuse to make any Advance. However, in its sole discretion, if the Fund makes an Advance in the absence of an Agreement, or if the Fund makes an Advance in error, that Advance will not waive, compromise, diminish, release or otherwise prejudice any of the Fund's rights to reimbursement or subrogation. The Agreement shall be in a form provided by or on behalf of the Fund. If the Covered Individual is a minor or incompetent to execute that Agreement, that person's parent, the Participant (in the case of a minor Dependent child), the Participant's spouse, or legal representative (in the case of an incompetent adult) must execute that Agreement upon request by the Fund. A Covered Individual must comply with all of the terms of the subrogation and reimbursement agreement, including the establishment of a trust for the benefit of the Fund. In this regard, the Covered Individual agrees that out of any recovery he receives from any Source or Coverage, as described in subsection (1) above, the identified amount that the Fund has Advanced or is obligated to Advance in benefits will be immediately deposited into a trust for the Fund's

benefit and the Fund shall have an equitable lien by agreement in the amount set forth in this paragraph which shall be enforceable as part of an action to enforce the Plan terms under ERISA Section 502(a)(3), including injunctive action to ensure that these amounts are preserved and not disbursed;

4. The Fund's equitable lien by agreement imposes a constructive trust upon the assets received as a result of a recovery by the Covered Individual, as opposed to the general assets of the Covered Individual, and enforcement of the equitable lien by agreement does not require that any of these particular assets received be traced to a specific account or other destination after they are received by the Covered Individual;
5. The Agreement will grant the Fund a priority, first dollar security interest and a lien in any recovery received from any Source or from any Coverage, whether by suit, settlement or otherwise, whether there is a full or partial recovery and regardless of whether the amounts are characterized or described as payment for medical expenses or as amounts other than for medical expenses of such Illness or Injury;
6. Acknowledges that the Fund specifically disavows the common fund doctrine, attorneys fund doctrine, fund doctrine, the double-recovery rule or any similar doctrine or theory, including the contractual defense of unjust enrichment. This means that the Fund's subrogation and reimbursement rights apply on a priority, first dollar basis to any recovery by the Covered Individual from any Source or Coverage without regard to legal fees and expenses of the Covered Individual. This also means the Covered Individual will be solely responsible for paying all legal fees and expenses in connection with any recovery from any Source or Coverage for the underlying illness or injury, and the Fund's recovery shall not be reduced by such legal fees or expenses;
7. Acknowledges that the Fund specifically disavows the make-whole rule or any other similar doctrine or theory. This means that the Fund's subrogation and reimbursement rights shall apply on a priority, first dollar basis to any recovery by a Covered Individual from any Source or Coverage, whether by suit, settlement or otherwise, whether there is a partial or full recovery and regardless of whether the Covered Individual believes he did not receive the amount that he is entitled to receive, or if the amounts are categorized or described as medical expenses or as amounts other than for medical expenses;
8. Agrees that if the recovery is reduced due to a Covered Individual's negligence (sometimes referred to as contributory negligence) or any other common law defense, the amount of the Plan's reimbursement is not affected or reduced;
9. Agrees that the Fund's right to reimbursement applies regardless of the existence of any state law or common law rule (including, but not limited to, the Illinois Workers' Compensation Act, 820 ILCS 305/1, et seq. and the Illinois Wrongful Death Act, 740 ILCS 180/0.01, et seq.) that would serve to ban or limit recovery of the Advance by the Fund from the Covered Individual or from any other Source;
10. Agrees that the Fund's right to reimbursement applies regardless of the existence of any state law or common law rule that would ban recovery from a person or entity that caused the illness or injury, or from the insurer of that person or entity (sometimes referred to as the "collateral source" rule);
11. Agrees not to do anything that will waive, compromise, diminish, release or otherwise prejudice the Fund's reimbursement rights or subrogation rights;
12. Agrees to notify and consult with the Fund or its designee in writing before starting any legal action or administrative proceeding against a Third Party alleged to be responsible for the Illness

or Injury that resulted in the Advance, and before entering into any settlement agreement with that Third Party or Third Party's insurer based on those allegations;

13. Agrees that the Fund has the right to suspend all benefit payments due to the Covered Individual and family member of the Covered Individual arising out of the current incident or any other unrelated future illness or injury until the Fund is fully reimbursed related to the Covered Individual;
14. Recognizes that no loan transaction is intended to be created under any subrogation or reimbursement agreement; and
15. Agrees not to assign a Covered Individual's rights with respect to subrogation and reimbursement to anyone (except as otherwise stated in this section). This means that a Covered Individual cannot give anyone else the right to pursue whatever rights that a Covered Individual has or had with respect to subrogation and reimbursement. Any attempt to do so will be void and have no effect.

C. For purposes of these provisions on subrogation and reimbursement, the term "Covered Individual" shall also include representatives, guardians, trustees, estate representatives, heirs, executors, administrators of special needs trusts and any other agents, persons or entities that may receive a benefit on behalf of or for Covered Individuals.
D. The Fund's subrogation and reimbursement rights and the Covered Individual's obligation set forth above shall apply regardless whether the Covered Individual executes a subrogation and reimbursement agreement.
E. For purpose of the subrogation and reimbursement provisions, benefits that are paid for medical, Hospital, Behavioral Health and Substance Use Disorders, Dental, Vision, Prescription Drug and the Short-Term Disability benefit (except relating to an accelerated death benefit) are recoverable through subrogation or reimbursement.

Recovery of Erroneous or Fraudulent Claims

The Fund will pay claims only when covered under the terms of the Plan provisions under which you are eligible. If the Fund pays Claims that it is not required to pay, it may recover and collect payments from you or any other entity or organization that it was required to make the payment to or that received an erroneous payment. The Fund will be permitted to pursue legal and equitable remedies to recover overpayments. The Fund may recover such erroneous payments and related amounts by offsetting or reducing any future benefit amounts payable to the Covered Individual and eligible Dependents of the Covered Individual.

You and your eligible Dependents may lose eligibility for coverage if you knowingly commit fraud against the Plan, for example, by filing claims for benefits to which you are not entitled, or for failing to report other available benefits coverage or your rights against a third party or Insurance Company in connection with a health Claim, and will be required to repay any monies paid. You may also be subject to legal action by the Fund.

For more information on the Fund's Subrogation procedures, contact the Health Benefits Department at 312-787-9455. Service Representatives are available Monday–Friday, 8:00 a.m. to 4:30 p.m. (CT).

Women's Health and Cancer Rights Act of 1998 (WHCRA)

You or your Dependents may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Aesthetic flat closures;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

Plan limits, Deductibles, Co-payments, and Coinsurance apply to these benefits. For more information on WHCRA benefits, contact the Health Benefits Department at 312-787-9455.

Coverage for Maternity Hospital Stay

Under federal law, the Plan may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider, in consultation with the mother of the newborn, from discharging the mother or newborn earlier than 48 or 96 hours, as appropriate.

Privacy of Health Information

Under federal law, the Plan protects your health information and keeps it strictly confidential. This includes protecting your health information from unauthorized disclosure. Health information includes personal health information that is transmitted or maintained by electronic media or in any other format. You will receive a notice of the Plan's practices and procedures regarding protecting health information, or you may obtain a copy of the Plan's Privacy Notice on the website at ***carpenterbenefits.org***.

In general, the Plan will use or disclose your health information only for treatment, payment or health care operations. The Plan will disclose your health information for other purposes only if you authorize this disclosure. You are entitled to know when and to whom disclosure has been made for any reason that is not for treatment, payment and health care operations, with certain exceptions.

The Plan will disclose your health information to you. You will be allowed to inspect and obtain a copy of your information, except for psychotherapy notes. You have the right to amend and correct your own health information. The Plan will not use or disclose health information without the consent or authorization of the patient, except as required or permitted under the law.

In the unlikely event that your protected health information is breached, the Plan will comply with breach notification rules under the Health Insurance Portability and Privacy Act ("HIPAA").

In the administration of the Plan, the Plan will make every effort to use only summarized health information or to only disclose health information that has been stripped of all identifying data. The Plan will take all necessary steps to ensure that health information is not used to perform any function that is not related to the Plan.

To protect your health information, the Plan has designated a privacy officer, to ensure that all health information is protected. Reasonable administrative, physical and technical safeguards are in place to protect

against intentional or accidental disclosure or misuse. The Plan makes every attempt to ensure that any agent, vendor, subcontractor, etc., to whom it provides health information agrees to do the same, and to report to the Plan any security incident. If possible, the Plan will return or destroy your health information when it is no longer needed for the purpose for which the disclosure was made.

If you believe that your health information has been misused or disclosed when it should not have been disclosed, you may contact the Privacy Officer of the Plan to challenge or dispute the use or disclosure of your health information. If the Plan determines that your health information has been misused or disclosed to anyone who should not have received it, then the Plan will do everything possible to minimize any harm that has been done. The Plan makes every effort to ensure that its vendors, subcontractors or any individual that performs any function for the Plan or assists the Plan in any function, protect your health information in the same way.

Administrative Plan Information

Plan Name	Mid-America Carpenters Regional Council Health Fund
Plan Sponsor	A Board of Trustees is responsible for the operation of the Plan. Although the Trustees are legally designated as the Plan Administrator, they have delegated certain administrative responsibilities to an Administrator. The Administrator and the Fund staff, under the Administrator's supervision, maintain eligibility records, account for employer contributions, answer participant inquiries, process Claim and benefit payments and handle other administrative functions.
Trust Fund	The Board of Trustees holds all assets in trust pursuant to the Trust Agreement. All benefits and administrative expenses are paid from the Fund's assets except for Life Insurance and Accidental Death and Dismemberment Insurance benefits under the Active Plan. The Trust Agreement consists of all the documents, including all amendments that establish the Trust Fund and its rules of operation.
Plan Identification Number	36-2229735
Plan Number	501
Plan Type	The Plan is an employee health benefits plan maintained to provide medical, prescription drug, dental, vision, disability, life and accidental death and dismemberment insurance for those who meet the eligibility requirements described in this SPD.
Plan Year	July 1 – June 30
Type of Funding	The benefits described in this SPD are self-funded except for Life Insurance and Accidental Death and Dismemberment Insurance benefits under the Active Plan, which are currently insured by MetLife Insurance Company. All self-funded benefits are limited to the Plan's assets available for payment of such benefits.
Collective Bargaining Agreements	The Plan is maintained pursuant to Collective Bargaining Agreements. The Fund Office will provide you, upon written request, information as to whether a particular employer is contributing to this Plan on behalf of Participants working under the Collective Bargaining Agreements. Copies of the Collective Bargaining Agreement may be obtained upon written request to your Local Union Office or: The Mid-America Carpenters Regional Council of the United Brotherhood of Carpenters and Joiners of America Attn: Contract Dept. 12 E. Erie Street Chicago, Illinois 60611 312-787-3076 The Collective Bargaining Agreements are also available for examination by the Participants at the Regional Council offices.
Agent for Service of Legal Process	For disputes arising under the Plan, service of legal process may be made on: Kristina M. Guastaferri, Executive Director Mid-America Carpenters Regional Council Health Fund 12 E. Erie Street Chicago, IL 60611 312-787-9455 Service of any legal process may also be made on any individual Trustee at the address for the Fund Office.

Amendment and Termination	The Board of Trustees has the right to amend or terminate the Plan in whole or in part at any time.	
Claims Fiduciaries	**Medical, Eligibility, Dependent Status, Short Term Disability, Maternity Leave, Vacation Savings Plan** Mid-America Carpenters Regional Council Health Fund 12 E. Erie Street Chicago, IL 60611 312-787-9455 carpenterbenefits.org **Specialty Prescription Drugs** Accredo Specialty 800-803-2523 accredo.com **Life Insurance and AD&D Claims** MetLife PO Box 6100 Scranton, PA 18505-6100 800-MET-6420	**Prescription Drugs and Mail Order** Express Scripts, Inc. Attn: Appeals Department P.O. Box 66587 St. Louis, MO 63166-6587 800-946-3979 – Administrative Appeals 800-935-6103 – Clinical Appeals express-scripts.com **Vision** VSP Vision Care 800-877-7195 vsp.com **Dental** Delta Dental of Illinois Attn: Appeals Committee 111 Shuman Blvd. Naperville, IL 60563 800-323-1743 deltadentalil.com
No Vesting	No benefits vest under the Fund.	
Restatement Date of SPD	This SPD is effective as of March 1, 2026.	
Board of Trustees	**UNION TRUSTEES** Gary Perinar | United Brotherhood of Carpenters Chairman of the Board of Trustees 12 E. Erie Street Chicago, Illinois 60611 Kevin McLaughlin | MACRC, EST 12 E. Erie Street Chicago, Illinois 60611 Anthony Guida| MACRC, Vice President 12 E. Erie Street Chicago, Illinois 60611 Rocky Kloth | MACRC Senior Director 8955 E. 38th Terrace, Kansas City, MO 64129 Steve Pinkley | St. Louis Regional Director 1401 Hampton Avenue, St. Louis, MO 63139 Joel Pogose | MACRC, President 12 E. Erie Street Chicago, Illinois 60611	**EMPLOYER TRUSTEES** Gerald W. Thiel, Jr. | G.W. Thiel, Inc. Secretary of the Board of Trustees 2872 Corporate Parkway, Algonquin, IL 60102 Mike Forest | RB Construction, Inc. 220 Gerry Drive, Ste 100, Wood Dale, IL 60191 Kevin Geshwender | Berglund Construction 8410 S. Chicago, Chicago, IL 60617 Gerhard Glassl, P.E. | The Up Companies 2060 Craigshire Rd., St. Louis, MO 63146 Brian Murphy | BAM Contracting LLC 2342 LaSalle Street, St. Louis, MO 64106 Michael W. Sudol |Bulley & Andrews 1755 W. Armitage Avenue, Chicago, IL 60622

Plan Administrator	Breanna Radtke Mid-America Carpenters Regional Council Health Fund 12 E. Erie Street Chicago, IL 60611
No Guarantee of Employment	Your coverage by the Plan does not constitute a guarantee of your continued employment.
Plan Inspection	If you want to inspect or receive copies of additional documents relating to the Plan, contact the Administrator at the Fund Office. You will be charged a reasonable fee to cover the cost of copying any documents requested.

Rescission

The Plan will not rescind health coverage under the Plan with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the Plan, unless the individual (or persons seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud or the individual makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan.

For purposes of the Plan, a rescission means a cancellation or discontinuance of Plan coverage for health benefits that has a retroactive effect. A cancellation or discontinuance of coverage is not a rescission if the cancellation or discontinuance has only a prospective effect. A cancellation or discontinuance is not a rescission if the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage. Retroactive elimination of coverage back to the date of termination of employment is not a rescission if due to a delay in administrative recordkeeping if the Employee does not pay any premiums for coverage after termination of employment. A cancellation or discontinuance is not a rescission if the cancellation or discontinuance of coverage is effective retroactive to the date of divorce.

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

Discretionary Authority

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

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

Plan Amendment and Plan Termination

Any amendment made by the Trustees will be reduced to writing and may be effective prospectively or retrospectively, to the extent allowed under the law, provided, however, no amendment to the Plan will retroactively reduce benefit entitlement or benefit levels then in effect. All amendments are subject to the limitation of the Trust Agreement and the applicable law and administrative regulations. The Trustees reserve the right to terminate the Plan or any part of the Plan and its benefits at any time. Written notice of amendment or termination of the Plan will be provided to you in accordance with federal regulations.
Furnishing Required Information and Documentation

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

ERISA Rights

As a participant in the Mid-America Carpenters Regional Council Health Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), which provides that all Plan Participants will be entitled to:

- Examine, without charge, at the Fund Office, all documents governing the Plan. These include insurance contracts, Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 Series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA);
- Obtain, upon written request to the Fund Administrator, copies of documents governing the operation of the Plan, including insurance contracts, Collective Bargaining Agreements and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Fund Administrator may make a reasonable charge for the copies; and
- Receive a summary of the Fund's annual financial report. The Fund Administrator is required by law to furnish each Participant with a copy of this Summary Annual Report.

Continue Group Health Plan Coverage

You have the right to continue health care coverage if there is a loss of coverage under the Plan as a result of a qualifying event, as described in the section titled Continuation Coverage under COBRA. You have to pay for such coverage, if elected. Review this Summary Plan Description and the documents governing the Plan for rules governing Continuation Coverage under COBRA.

Prudent Actions by Plan Fiduciaries

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

Enforcing Rights

If a Claim for benefits is denied or ignored, in whole or in part, the Participant has the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and if you do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim that is denied or ignored, in whole or in part, you may file suit in a state or federal court. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claim and appeal procedures. 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 you believe that Plan fiduciaries have misused the Plan's money, or if you believe that you have been discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or may file suit in a federal court. The court will decide who should pay costs and legal fees. If you are successful, the court may order the person sued to pay costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds the claim is frivolous.

Assistance with Questions

If you have any questions about Plan benefits, you should contact the Administrator. If you have any questions about this document or about your rights under ERISA, or if assistance is needed in obtaining documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration (EBSA) at:

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

Local Office
Employee Benefits Security Administration Chicago Regional Office
200 W. Adams Street Suite 1600
Chicago, Illinois 60606

For more information about your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by visiting the website at dol.gov/ebsa. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of EBSA at 1-866-444-3272.

Glossary of Terms

Whenever a word or phrase defined in this section is used in this Plan, it shall have the same meaning as defined below unless a different meaning is plainly required by the context. The masculine gender, where appearing in the Plan, shall be deemed to include the feminine gender and the singular shall be deemed to include the plural, unless the context clearly indicates to the contrary.

Active Plan/Active Plan of Benefits
"Active Plan" or "Active Plan of Benefits" means this Plan and the Plan of Benefits as described in this Summary Plan Description dated January 1, 2026, for the Active Plan of Benefits and the Schedule of Benefits for the Active Plan.

Administrator/Plan Administrator/COBRA Administrator
"Administrator," "Plan Administrator" and "COBRA Administrator" means the entity or individual designated by the Trustees to act as the executive administrative officer of the Trust Fund who has the authority to control and manage the administration of the Plan.

Affordable Care Act
The "Affordable Care Act" means the Patient Protection and Affordable Care Act, Public Law No. 111-148, and the Health Care and Education Reconciliation Act of 2010, Public Law No. 111-152 and the regulations and guidance promulgated thereunder (the "Affordable Care Act").

Appeals Committee
"Appeals Committee" means a committee of Trustees appointed by the Board of Trustees to handle appeals brought pursuant to the procedures set forth in the Plan Document.

Apprentice Program
The "Apprentice Program" means the Mid-America Carpenters Regional Council Apprentice and Training Program.

Authorized Personal Representative
"Authorized Personal Representative" means the person designated by a Claimant by means of the Fund's Authorized Personal Representative Form or Health Care Power of Attorney to act on his behalf in receiving any information that is (or would be) provided to a Participant/beneficiary of the Plan, including but not limited to, any and all information that relates to his claim for coverage or benefits under the Plan and any individual rights that a Covered Individual has regarding his protected health information under HIPAA.

Behavioral Health Disorders
"Behavioral Health" means a neurosis, psychoneurosis, psychopathy, psychosis, or a mental or emotional disease of any kind that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including Substance Use Disorders.

Calendar Quarter
"Calendar Quarter" means any three-month period beginning on January 1, April 1, July 1 or October 1.

Calendar Year
"Calendar Year" means a 12-month period starting on January 1 and ending on the following December 31.

Claim
"Claim" means a demand for payment under the Plan on behalf of a Claimant pursuant to the procedures for making such requests set forth in the Plan Document.

Claimant
"Claimant" means a Covered Individual who requests a benefit to be paid to him under the procedures set forth in the Plan Document. A Claimant includes a Participant or the Participant's spouse, Participant's Dependent or Authorized Personal Representative authorized by the Covered Individual.

Claims Fiduciary
A "Claims Fiduciary" is the entity that has full discretionary authority to interpret the terms of the Plan and to decide benefit claims under the Plan and the appeal of such decision, and to maintain any applicable external review process. The Plan's Claims Fiduciary is the Board of Trustees unless the Trustees take action to delegate such authority to a third party Claims Fiduciary such as to an insurance carrier or to a third party service provider responsible for maintaining a benefit program under the Plan, e.g., a service provider maintaining the Plan's dental, vision, behavioral health, prescription drug or medical benefits as designated in this Summary Plan Description.

COBRA/Continuation Coverage under COBRA
"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time. "Continuation Coverage under COBRA" means coverage offered pursuant to COBRA.

Coinsurance
"Coinsurance" means the portion, expressed as a percentage, of Covered Services a Covered Individual will pay after the Calendar Year Deductible is satisfied, but before the Calendar Year Out-of-Pocket Maximum is met.

Collective Bargaining Agreement
"Collective Bargaining Agreement" means a written agreement between the Union and an Employer (or an association on behalf of an Employer) providing for Contributions by the Employer to the Trust Fund for an Employee, and pursuant to which an Employer consents to be bound by the Trust Agreement and the terms of the Plan and any amendment thereto.

Contracted Provider
"Contracted Provider" means an organization with which the Fund contracts for services on behalf of Participants and Covered Individuals, including, but not limited to provisions of a Preferred Provider Network, Utilization Review management, and other services related to Plan benefits.

Contributions
"Contributions" means payments made or due to the Fund by or from employers on behalf of Employees for work performed by such Employees, pursuant to the terms of the Trust Agreement, a Collective Bargaining Agreement, Participation Agreement or other written agreement.

Convalescent Facility
"Convalescent Facility" means an institution that:

A. Provides skilled nursing care under 24-hour-a-day supervision of a Physician or graduate Registered Nurse;
B. Has available, at all times, the services of a Physician who is a staff member of a Hospital;
C. Provides 24-hour-a-day nursing service by a graduate Registered Nurse, licensed vocational nurse, or skilled practical nurse and has a graduate Registered Nurse on duty at least eight hours per day;
D. Maintains a daily medical record for each patient; and
E. Is not a place for rest, a place for Custodial Care, a place for the aged, or a hotel or similar institution.

Coordination of Benefits
"Coordination of Benefits" means the provisions used to establish the order in which two or more plans coordinate their respective benefits so the total benefits paid do not exceed 100% of the total allowable charge.

Co-payment or Co-pay
"Co-payment" or "Co-pay" means the dollar amount a Covered Individual will pay for certain services before the Plan pays.

Cosmetic
"Cosmetic" means a procedure or treatment that is intended primarily to improve physical appearance, and/or to restore form, is not Medically Necessary and is not a treatment requirement.

Coverage Quarter
"Coverage Quarter" means the three-month period beginning on March 1, June 1, September 1 or December 1.

Covered Employment
"Covered Employment" means work performed by an Employee for an Employer for which Contributions for hours worked are required to be made to this Fund under a Collective Bargaining Agreement, Participation Agreement, or other written agreement.

Covered Individual
"Covered Individual" means a Participant and each Dependent eligible under the Active Plan or an individual who elects continuation of coverage under COBRA or the Low Cost Medical Plan.

Covered Medical Expenses, Covered Expenses or Covered Services
"Covered Medical Expenses," "Covered Expenses" or "Covered Services" means expenses for medical, prescription drugs, vision and/or dental services or supplies that are Medically Necessary and required for treatment as a result of a Non-Occupational Illness or Injury for which benefits are payable by the Plan in accordance with Plan provisions.

Custodial Care
"Custodial Care" means services and supplies for care:

A. Provided mainly to help the patient with activities of daily living (ADL), including, but not limited to, walking, getting in or out of bed, exercising or moving the person, bathing, using the toilet, administering enemas, dressing and assisting with hygiene needs, assistance with eating, tube feeding, or gastronomy feeding, cleaning, preparation of meals, acting as companion or sitter, administering or supervising the administration of medication, or as part of a Maintenance Care Treatment Plan not reasonably expected to improve the patient's condition, illness, injury or functional ability, rather than to provide medical treatment;
B. That can safely and adequately be provided by persons who do not have the technical skills of a health care provider; and
C. That meet one of the conditions above regardless of:
    1) Who recommends, provides or directs the care;
    2) Where the care is provided; or
    3) Whether or not the patient or another caregiver can be or is being trained to care for himself

Deductible
"Deductible" means the amount of Covered Medical Expenses a Covered Individual pays each Calendar Year before benefits are payable by the Plan.

Dentist
For a definition of "Dentist," see the definition of "Physician" on page 119.

Dependent
See page 12 for definition.

Developmental Disability
"Developmental Disability" means a severe, chronic impairment which originated at birth or during childhood, is expected to continue indefinitely, and substantially restricts the individual's functioning in several major life activities. More specifically, a Developmental Disability is a severe, chronic impairment which satisfies each of the following requirements:

A. Is attributable to a mental or physical impairment or a combination of mental and physical impairments;
B. Is manifested while a Dependent;
C. Results in substantial functional limitations in three or more of the following areas of major life activity:
    1) Self-care;
    2) Receptive and expressive language;
    3) Learning;
    4) Mobility;
    5) Self-direction;
    6) Capacity for independent living; and
    7) Economic self-sufficiency.
D. Results in the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

Disability or Disabled
"Disability" means an illness or injury that results in an Employee being unable to perform the duties of his occupation. The Employee must be under the active care of a licensed Physician during the entire period of the Disability and cannot be engaged in any other occupation for wage or profit.

Doctor
For a definition of "Doctor," see the definition of "Physician" on page 119.

Durable Medical Equipment (DME) and Supplies
"Durable Medical Equipment (DME) and Supplies" means a device or instrument of a durable nature approved by the Food and Drug Administration (FDA) that:
Can withstand repeated use;

A. Is primarily and customarily used to serve a medical purpose, rather than a comfort or convenience purpose and is not generally useful in the absence of an Illness or Injury;
B. Is not disposable or non-durable;
C. Is appropriate for home use, ordered or prescribed by a Physician and is exclusively needed by the recipient for whom it was approved;
D. Generally includes, but is not limited to, wheelchairs, walkers, Hospital beds, respiratory supplies including nebulizers, breast pumps and supplies required for sleep apnea;
E. Repair, maintenance and replacement of equipment is limited and is based on medical necessity; and
F. Does not include home modifications to accommodate equipment.

Durable Medical Equipment (DME) Provider
"Durable Medical Equipment (DME) Provider" means a supplier of DME that is licensed by a state and accredited as a supplier of DME.

Emergency or Emergencies
"Emergency" means a severe condition that results from acute symptoms that a prudent layperson with average knowledge of health and medicine would expect the absence of immediate medical attention to result in:

A. Placing the health of the individual, including the health of an unborn child, in serious jeopardy;
B. Serious impairment to bodily functions; or
C. Serious dysfunction of any bodily organ or part.

Emergency Room
"Emergency Room" means the section of a legally licensed Hospital facility staffed and equipped to provide rapid treatment for victims of sudden Illness, Injury or trauma. "Emergency Room" also means an independent freestanding emergency department that is geographically distinct and licensed separately from a Hospital under the laws of the state of its jurisdiction and provides Emergency Services.

Emergency Services
"Emergency Services" means any medical or screening exam and treatment necessary to evaluate and stabilize the patient and any post-stabilization services rendered to the patient admitted through an Emergency Room.

The following are not considered "post-stabilization services":

A. The attending Physician or treating provider determines the patient is able to travel using nonmedical transportation to an available PPO Provider located within a reasonable travel distance;
B. The Non-PPO Provider performing covered services satisfies the notice and consent requirements of the No Surprises Act;
C. The patient (or the person authorized to provide consent on their behalf) is in a condition to provide informed consent; and
D. The Non-PPO Provider satisfies any additional requirements or prohibitions imposed under state law.

Employee
"Employee" means any individual employed by an Employer:
In a bargaining unit represented by the Union for whom the Employer is obligated to contribute to the Health Fund pursuant to a Collective Bargaining Agreement.
For whom the Employer is obligated to contribute to the Health Fund pursuant to a written Participation Agreement or other written agreement.
Sole proprietors, partners and other unincorporated owner/operators do not qualify as "Employees."

Employer or Contributing Employer
"Employer" or "Contributing Employer" has the meaning assigned to it in the Trust Agreement.

ERISA
"ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time. Reference to any section or subsection of ERISA includes reference to any comparable or successor provisions of any legislation that amends, supplements, or replaces such section or subsection.

Experimental or Investigational
"Experimental" or "Investigational" means the use of any treatment modality, service, procedure, facility, equipment, drug, device, surgery, or supply if it meets one or more of the following criteria:
A. It has failed to obtain final approval for use of a specific service, procedure, drug, device, surgery or treatment modality for specific diagnosis from the appropriate governmental regulatory body;
B. Reliable evidence does not establish a consensus conclusion among experts recognizing the safety and effectiveness of the specific service, procedure, drug, device, surgery, or treatment modality on health outcomes for a specific diagnosis;
C. If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, surgery, treatment or procedure, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, which makes it Experimental/Investigational, or if federal law requires such review or approval;
D. If 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 tolerant dose, its toxicity, its safety, or its efficacy as compared with a standard means of treatment or diagnosis; or
E. If 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 experimental or research clinical trials, or is otherwise under study by corresponding trials sponsored by the FDA, the National Cancer Institute, the National Institute of Health or similar body to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with a standard means of treatment or diagnosis.

Notwithstanding the foregoing, to the extent required under the Affordable Care Act, the Plan will not deny you the right to participate in certain approved clinical trials; deny, limit or impose additional conditions on the coverage of routine patient costs furnished in connection with participation in the clinical trial; and will not discriminate against you for participating in the clinical trial. For more information on the specific services and clinical trials covered, please call the Fund Office.

Reliable evidence shall mean only published reports and articles in the 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.
The Trustees or a delegated third-party Claims Fiduciary shall have authority to determine, in their discretion, whether a service, procedure, facility, equipment, drug, device, surgery, supply or treatment modality is Experimental/Investigational. The fact that a Physician has prescribed, ordered, recommended or approved the service, procedure, facility, equipment, drug, device, surgery or treatment modality does not, in itself, make it eligible for payment.

Extended Care/Skilled Nursing Facility
"Extended Care/Skilled Nursing Facility" means a nursing facility that:

A. Is an institution, or a distinct part of an institution that has in effect a transfer agreement with one or more Hospitals;
B. Is primarily engaged in providing inpatient skilled nursing care and related services for individuals who require medical or nursing care;
C. Is duly licensed by the appropriate governmental authorities;
D. Has one or more Physicians and one or more registered professional nurses responsible for the care of inpatients;
E. Requires that every patient must be under the supervision of a Physician;
F. Maintains clinical records on all patients;
G. Provides 24-hour a day nursing services;
H. Provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;
I. Has in effect a Utilization Review management plan;
J. Is eligible to participate under Medicare;
K. Is not an institution that is primarily for the care and treatment of mental diseases or tuberculosis; and
L. Rehabilitation services are for the rehabilitation of a Covered Individual with an Injury, Illness or Disability.

FMLA
"FMLA" means the Family Medical Leave Act of 1993, as amended from time to time.

Fund, Trust Fund, or Health Fund
"Fund," "Trust Fund," or "Health Fund" means the Mid-America Carpenters Regional Council Health Fund.

Gene-Based Cell Therapy
"Gene-Based Cell Therapy" involves removing cells from a patient, altering them using gene therapy, and then implanting the modified cells back into the patient's body.

Gene Therapy
"Gene Therapy" means a therapy that modifies a person's genes to treat or cure disease. Gene therapies can work by several mechanisms: replacing a disease-causing gene with a healthy copy of the gene, inactivating a disease-causing gene that is not functioning properly, or introducing a new or modified gene into the body to help tread a disease, whether those therapies have received approval from the U.S. Food and Drug Administration (FDA) or are considered experimental or investigational

HIPAA
"HIPAA" means the Health Insurance Portability and Accountability Act of 1996 as amended from time to time.

Home Health Agency
"Home Health Agency" means a program of care provided by a public agency or private organization, or a subdivision of such agency or organization that:

A. Is primarily engaged in providing skilled nursing services and other therapeutic services in the homes or places of residence of its patients;
B. Has established policies for governing the services it provides, such policies being established by a group of professional personnel associated with the agency or
C. organization, including one or more Physicians and one or more registered professional nurses;
D. Provides for the supervision of its services by a Physician or registered professional nurse acting under a Physician's direction;
E. Maintains clinical records of all patients;
F. Is licensed according to the applicable law of the state in which it is located or provides services;
G. Is certified or approved by Medicare and is eligible to participate under Medicare; and
H. Is not primarily for the care of Behavioral Health and Substance Use Disorders.

Hospice or Hospice Facility
"Hospice" or "Hospice Facility" means an agency or organization that administers a program of palliative and supportive health care services (also known as "core services") providing physical, psychological, nursing, dietary, social, and spiritual care for terminally ill persons assessed to have a life expectancy of six months or less. The agency must:

A. Be approved by Medicare as a Hospice program; and
B. Be licensed or certified as a Hospice by the regulatory authority having responsibility for the licensing or certification under the laws of the jurisdiction in which it is located; or, if licensing is not required, the agency must:
    1) Provide service 24 hours per day, seven days per week;
    2) Be under the direct supervision of a duly qualified Physician;
    3) Have a full-time administrator;
    4) Have a nurse coordinator who is a Registered Nurse (RN) with four years of full-time clinical experience (two of these years must involve caring for terminally ill patients);
    5) Have a main purpose of providing Hospice services;
    6) provided to the patient;
    7) Maintain malpractice insurance coverage; and
    8) Have established policies governing the provision of Hospice care, assess the patient's medical and social needs, develop a Hospice care program and provide or otherwise arrange for services to meet those needs.

Hospital
"Hospital" means an institution engaged primarily in providing medical care and treatment to individuals who have an Illness or Injury on an inpatient basis at the patient's expense, and that fully meets one of the following requirements:

A. It is a Hospital accredited by the Joint Commission;
B. It is a Hospital, as defined by Medicare, that is qualified to participate in and eligible to receive payments under and in accordance with the provisions of Medicare; or
C. It is an institution that:
    1) In return for payment from its patients, provides on an inpatient basis, diagnosis and therapeutic facilities for the medical and surgical diagnosis, treatment and care of injured and ill individuals under the supervision of a staff of Physicians licensed to practice medicine;
    2) Provides on the premises 24-hour-a-day nursing services by or under the supervision of a registered graduate nurse; and
    3) Operates continuously with organized facilities for operative surgery on the premises and is not a place for rest, for the aged, a Residential Treatment Facility, a nursing or convalescent center or rehabilitation center.

Illness
"Illness" means a sickness, disorder, or disease that is Non-Occupational. Pregnancy is included in the definition of "Illness" under this Plan.

Infusion Therapy
"Infusion Therapy" means the administration of medications, nutrients or other solutions into the blood stream/digestive system, or the membranes surrounding the spinal cord, or under the skin, which are prescribed by a Physician and obtained at a licensed, accredited pharmacy for conditions that include, but are not limited to infections, cancer, blood disorders and other comparable health problems.

Injury or Accident
"Injury" or "Accident" means any damage to a body part resulting from trauma from an external source that is Non-Occupational.

Insurance Company
"Insurance Company" means the Contracted Provider providing the Vision Insurance, Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance benefits.

Long Term Medication
"Long Term Medication" means a medication that must be taken on a regular basis to treat a chronic health condition.

Low Cost Medical Plan
"Low Cost Medical Plan" refers to this Plan and the Plan of Benefits as described in this Summary Plan Description dated January 1, 2026, for the Active Plan of Benefits. The "Low Cost Medical Plan" is the portion of the Plan that covers Employees who elect to continue health coverage, in lieu of continued coverage under COBRA, when Active Plan eligibility terminates.

Maintenance Care
"Maintenance Care" means services and supplies provided primarily to maintain, support, or preserve a level of physical or mental function rather than to improve such function.

Medicaid
"Medicaid" means a health insurance program under Title XIX of the Social Security Act for certain people and families with low incomes and resources as provided under Title 42, Chapter IV of the Code of Federal Regulations.

Medically Necessary or Medical Necessity

A. "Medically Necessary" means only those services, treatments, or supplies provided by a Hospital, a Physician or other qualified provider of medical services and supplies that are required in the judgment of the Trustees, based on the opinion of a qualified medical professional, to identify or treat the illness or injury of a Covered Individual. A medical service, treatment or supply shall not be considered to be Medically Necessary solely because a Physician or Doctor orders or recommends it. "Medical Necessity" refers to a service, treatment or supply that is "Medically Necessary."
B. To be considered Medically Necessary, the service, treatment, or supply must:
    1) Be consistent with the symptoms or diagnosis and treatment of the eligible Covered Individual's condition, Illness, Injury, disease, or ailment;
    2) Be appropriate according to industry standards of good and generally accepted medical practice;
    3) Not be solely for the convenience of a Covered Individual, a Physician or a Hospital;
    4) Be the most appropriate treatment, services or supplies that can safely be provided to a Covered Individual; and
    5) Not be considered Experimental or Investigational.
C. A medical service or supply will be considered "appropriate" if, both with respect to the illness or injury involved and the Covered Individual's overall health condition:
    1) It is a diagnostic procedure that is called for by the health status of the Covered Individual and is as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than any alternate service or supply, both with respect to the Illness or Injury involved and the Covered Individual's overall health condition; and
    2) It is care or treatment that is as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than any alternate service or supply, both with respect to the Illness or Injury involved and the Covered Individual's overall health condition.
D. A medical service or supply can be deemed Medically Necessary if all the following conditions are satisfied:
    1) The service or supply is for a Disabled Dependent who has a documented developmental or cognitive disability that significantly impairs communication or comprehension;
    2) The service or supply is supported by the treating Physician as the most appropriate option for the Dependent's condition; and
    3) Alternative standard services or supplies are not feasible due to the Dependent's limitations.
E. A service, treatment, or supply may be deemed Medically Necessary even if it would not otherwise meet the criteria above, provided all the following conditions are met:
    1) The service, treatment or supply is for a Dependent who has a documented developmental or cognitive disability that significantly impairs communication or comprehension, and that materially limits or prevents the Dependent from receiving standard diagnostic or treatment methods, or supplies; and

2) The alternative service, treatment, or supply is supported by the treating Physician as the most appropriate option for the Dependent's condition.

Medicare
"Medicare" means the federal health insurance program for individuals 65 years or older, younger than 65 with disabilities or with end stage renal disease, designated as the Health Insurance for the Aged Program under Title XVIII of the Social Security Act, as such Act was amended by the Social Security Amendments of 1965 (Public Law 89-97), and as such program is currently constituted, and as it may be amended from time to time.

Member in Good Standing
The Fund will deem a Participant to be a "Member in Good Standing" for periods in which the Union advises that the Participant is in good standing under the Constitution of the United Brotherhood of Carpenters and Joiners.

Negotiated Rate
"Negotiated Rate" means an amount for services rendered that does not exceed the amount agreed upon under the contract between the Health Fund's Contracted Provider and the service provider who participates in the Contracted Provider's Network.

Network
"Network" means a group of independent Doctors, Hospitals or other health care providers who have agreed to contract with a single organization with which the Plan contracts for services.

No Surprises Act
"No Surprises Act" means the No Surprises Act portion of the Consolidated Appropriations Act, 2021, its implementing regulations and other underlying guidance.

Non-Bargained Employee
"Non-bargained Employee" means an employee for whom an Employer is obligated to contribute to the Fund pursuant to a Participation Agreement or other written instrument.

Non-Occupational or Non-Occupational Illness or Injury
"Non-Occupational" or "Non-Occupational Illness or Injury" means:

A. Any injury that does not arise out of and in the course of the Covered Individual's employment, or
B. Any Illness that is not caused or aggravated by employment, for which benefits are not payable in whole or in part under any Workers' Compensation Law, Employer's Liability Law, Occupational Diseases Law, or similar law.

Non-Preferred Provider, Non-PPO or Out-of-Network
"Non-Preferred Provider," "Non-PPO" or "Out-of-Network" means Doctors, Hospitals or other health care providers who do not participate in the Networks of the Fund's Contracted Providers.

Occupational or Work-Related Illness or Injury
"Occupational Illness or Injury" or "Work-Related Illness or Injury" means:

A. Any injury arising out of and in the course of the Covered Individual's employment, or
B. Any illness caused or aggravated by employment, for which benefits are, or may be, payable in whole or in part under any Workers' Compensation Law, Employer's Liability Law, Occupational Diseases Law, or similar law.

Office Employee
A non-bargained Employee for whom a signatory contractor Employer is obligated to contribute to the Fund pursuant to a Participation Agreement or other written instrument.

Office Visit
"Office Visit" means a direct personal contact between a Physician or other health care practitioner and a Covered Individual as a patient in the office of the Physician or health care practitioner for diagnosis or treatment associated with the use of the appropriate Office Visit Code in the Current Procedural Terminology (CPT) manual of the American Medical Association or the Current Dental Terminology (CDT) manual of the American Dental Association and with documentation that meets the requirements of such CPT coding. Neither a telephone discussion with a Physician or other health care practitioner, nor a visit to a health care practitioner's office solely for such services as blood drawing, leaving a specimen, receiving a routine injection or completing medical forms is considered to be an Office Visit for the purpose of this Plan.

Out-of-Pocket Maximum
"Out-of-Pocket Maximum" means the maximum amount that a Covered Individual is required to pay for Covered Expenses within a specified period of time. After a Covered Individual satisfies the Plan's applicable Out-of-Pocket Maximum the Plan will pay 100% of any additional Covered Expenses a Covered Individual incurs for the remainder of the Calendar Year.

Outside Plan, Other Health Care Plan or Another Health Care Plan
"Outside Plan," "Other Health Care Plan" or "Another Health Care Plan" means a plan, other than this Plan, providing health coverage to a Participant or a Dependent of a Participant.

Participant
"Participant" means an Employee employed or previously employed in Covered Employment who meets the eligibility requirements or an individual who elects continuation of Plan coverage.

Participation Agreement
"Participation Agreement" means a written agreement between an Employer (as defined in the Trust Agreement) and the Trustees, in which the Employer agrees to become an Employer hereunder obligating the Employer to make contributions to the Fund on behalf of the Employer's covered Employees whether or not subject to the terms of a Collective Bargaining Agreement. The Trustees may also enter Participation Agreements with employers covering independent contractors retained by the employer.

Pension Plans
"Pension Plans" means collectively the Mid-America Carpenters Regional Council Pension Plan and the Carpenters Pension Fund of Illinois Plan.

Physician or Doctor
A. "Physician" or "Doctor" means an individual licensed in the state where such individual renders treatment and/or is acting within the scope of his license at the time and place the services are

performed. Additionally, to the extent required by the Affordable Care Act, if an individual's service is covered under the Plan, the Plan will not discriminate based on the practitioner's license or certification, if the practitioner is licensed to provide such services in the state in which the services are performed and the practitioner is acting within the scope of that license; and

B. "Physician" shall include a Doctor of Medicine (MD), a Doctor of Osteopathy (DO), a Doctor of Podiatric Medicine (DPM), a Doctor of Naprapathy (DN), a Doctor of Acupuncture and Oriental Medicine (DAOM), a Doctor of Acupuncture (DAC), a Doctor of Dental Science/Surgery (DDS), a Doctor of Medical Dentistry (DMD), a Doctor of Optometry (OD), a Doctor of Ophthalmology (MD-Ophthalmology), a Doctor of Chiropractic Medicine (DC), a Doctor of Psychology (PsyD), a Master of Social Work (MSW), a Licensed Clinical Professional Counselor (LCPC), a Licensed Clinical Social Worker (LCSW), a Board Certified Behavioral Analyst (BCBA), a Licensed Physical Therapist (LPT), a Licensed Occupational Therapist (OTR), a Licensed Speech/Language Pathologist (CCC-SLP), a Certified Registered Nurse Anesthetist (CRNA); a Certified Surgical Assistant (SA, CSA), an Advanced Practice Nurse (APN), a Nurse Practitioner (LPN, RN or NP), a Certified Nurse Practitioner (CNP), a Clinical Nurse Specialist (CNS), a Physician Assistant (PA), a Registered Nurse First Assistant (RNFA), a Certified Nurse Midwife (CNM), a Licensed Midwife (LM), and a Certified Pediatric Nurse (CPN).

Plan, Benefit Plan, Plan of Benefits or Health Plan
"Plan," "Benefit Plan," "Plan of Benefits" or "Health Plan" means this Mid-America Carpenters Regional Council Health Plan, or the plan or program of benefits provided by the Plan set forth in this document, including any other written document designated by the Trustees as constituting a part of the Plan, established, and as it may be amended from time to time by the Board of Trustees pursuant to the provisions of the Trust Agreement.

Preferred Provider Organization (PPO)
"Preferred Provider Organization (PPO)" means a group of independent Doctors, Hospitals or other health care providers who have agreed to contract with a single organization or Network with which the Plan contracts for services, also referred to as a Contracted Provider Network.

Premium Payment
"Premium Payment" means the amount a Covered Individual pays for Continuation Coverage under COBRA or the Low Cost Medical Plan. Premium Payments are subject to change from time to time.

Private Duty Nursing
"Private Duty Nursing" means skilled nursing service provided on a one-to-one basis by an actively practicing registered nurse or licensed practical nurse. Private Duty Nursing is shift nursing and does not include Custodial Care.

Protected Service
"Protected Service" means:

A. Emergency Services furnished by a Non-PPO provider or facility;
B. Air ambulance services furnished by a Non-PPO provider;
C. Non-emergency items and services, such as anesthesiology, pathology, radiology, diagnostic services and other services defined as ancillary services under the No Surprises Act furnished by a Non-PPO provider at a PPO facility;

D. Other items and services furnished by a Non-PPO provider at a PPO Hospital, Hospital outpatient department, or ambulatory surgical center if such items and services would be covered by the Plan if furnished by a PPO provider and the provider does not satisfy the notice and consent requirements under the No Surprises Act.

Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice

"Qualified Medical Child Support Order" (QMCSO) or "National Medical Support Notice," as defined under ERISA, means a court order requiring a medical plan to provide medical benefits to the children of the parties pursuant to a marriage dissolution, divorce, child custody action, paternity suit, family non-support action, or other state domestic relations actions, where financial support of children is involved. The Fund will treat children who are the subject of a QMCSO or National Medical Support Notice as Dependents under the Plan pursuant to the Fund's procedures governing QMCSOs and National Medical Support Notices.

Reasonable and Customary Allowance, Reasonable and Customary Allowable Charge or Reasonable and Customary Charge

A. "Reasonable and Customary Allowance," "Reasonable and Customary Allowable Charge" or "Reasonable and Customary Charge" means the allowance or percentage for Medically Necessary services or supplies as determined by the Trustees (or their designee, such as a third party Claims Fiduciary) in their sole discretion, and amended from time to time, to be the lowest of (1) the usual charge by the provider or facility for the same or similar service or supply in the locality; (2) the applicable prevailing charge for medical, dental, vision, or prescription drug for services or supplies rendered by, or on behalf of, an Out-of-Network Provider; or (3) an amount not to exceed the negotiated charge.
B. Complexity of service will also be considered, but in no case will the Reasonable and Customary Allowance exceed charges actually incurred.
C. For Protected Services, the Reasonable and Customary Allowance shall be applied in accordance with the No Surprises Act.

Relevant

Information is "Relevant" if it:

A. Was relied upon by the Claims Fiduciary in making the decision;
B. Was submitted, considered, or generated regardless of whether it was relied upon; or
C. Demonstrates compliance with Claim processing requirements.

Relevant information for purposes of Health and Short Term Disability Claims includes but is not limited to:

A. New or additional information considered, relied upon or generated during the appeal as well as any new or additional rationale for the denial, if any;
B. Relevant internal rules, guidelines, protocol or other similar criteria;
C. Explanation of the scientific or clinical judgment that formed the basis of the adverse benefit determination if the Claim is denied based on Medical Necessity, Experimental treatment or similar exclusion or limit; and
D. The identity of any medical expert who provided a determination for a Claim.

Rescission

A "Rescission" is a cancellation or discontinuance of Plan coverage for Health and Short Term Disability benefits that has a retroactive effect. A cancellation or discontinuance of coverage is not a Rescission if:

A. The cancellation or discontinuance has only a prospective effect.

B. The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or Contributions toward the cost of coverage.
C. The retroactive elimination of health coverage back to the date of termination of employment is due to a delay in administrative recordkeeping if the Employee does not pay any premiums for coverage after termination of employment.
D. The cancellation or discontinuance of health coverage is effective retroactive to the date of divorce.

Residential Treatment Facility
A "Residential Treatment Facility" meets the following requirements:
A. It is established and operated in accordance with any applicable state law.
B. It is accredited either by the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF).
C. It provides a program of treatment approved by a Physician and the Treatment Plan administrator.
D. It has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient.
E. It provides at least the following basic services:
    1) Room and Board (if the medical plan provides for inpatient benefits at a treatment center).
    2) Conducts evaluation, diagnosis and treatment plans.
    3) Offers individual, group and/or family counseling.
    4) Provides referral and orientation to specialized community resources.
F. A treatment center that qualifies as a Hospital is covered as a Hospital and not as a treatment center.
G. The treatment provided meets the generally accepted behavioral health standards of care for the condition or impairment for which the individual is being treated for, and no alternative or lower level of care is available for the individual to be safely treated.

Room and Board or Room and Board Charges
"Room and Board Charges" means charges made by a Hospital, a Skilled Nursing/Extended Care Facility, or a Hospice Facility, on its own behalf for Room and Board at a semi-private room rate, general duty nursing, and any other charges that are regularly made by the Hospital or facility as a condition of occupancy of the class of accommodations occupied, but not including charges for professional services of a Physician or private duty nurse. Such charges are based on a confinement or stay of 24 hours or any shorter period for which the Hospital or facility regularly charges a full day's Room and Board rate.

Schedule of Benefits
"Schedule of Benefits" means the descriptive summary that highlights key features of the Plan of Benefits as determined by the Board of Trustees for the Active Plan and the Low Cost Medical Plan. The descriptive summary provides information regarding Plan Deductibles, Coinsurance and Co-pays.

Select Specialty Medication
"Select Specialty Medication" means a medication which is designated as a non-essential health benefit under the Affordable Care Act by the Plan's Contracted Provider. Select Specialty Medications are subject to the Specialty Pharmacy Copay Assistance Program.

Self-Payment of Hours
"Self-Payment of Hours" means payment by an Employee to continue coverage under the Active Plan when the Plan does not receive the required Contributions to maintain the Employee's coverage under the Plan.

Substance Use Disorder
"Substance Use Disorder" is psychological and/or physiological dependence on or addiction to alcohol, drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined in the current edition of the ICD or DSM.

Surgi-Center or Ambulatory Surgical Center
"Surgi-Center" also referred to as an "Ambulatory Surgical Center," means a facility that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization. The term does not include:

A. A facility that is licensed as part of a Hospital;
B. A facility that provides services and/or accommodations for patients who stay overnight; or
C. A facility that is used as an office or clinic for the private practice of a Physician, Podiatrist or Dentist except when:
    1) It holds itself out to the public or other health care providers as a free-standing surgical center or similar facility; or
    2) It is operated or used by a person or entity different from the Physician(s) that owns it; or
    3) Patients are charged a fee for the use of the facility in addition to the Physicians' professional services.

Treatment Plan
"Treatment Plan" means a written report, showing the recommended treatment of any Illness or Injury, prepared by a Covered Individual's attending Physician as a result of an examination made by a Physician.

Trust Agreement
"Trust Agreement" means the Mid-America Carpenters Regional Council Health Fund Trust Agreement as amended from time to time, establishing the Trust Fund and its rules of operation.

Trustee, Trustees, or Board of Trustees
"Trustee," "Trustees," or "Board of Trustees" means a Trustee or the Trustees of the Mid-America Carpenters Regional Council Health Fund.

Uniformed Services or Military Service
"Uniformed Services" or "Military Service" means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

Uniformed Services or Military Service covers the United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

Union or Council
"Union" or "Council" means the Mid-America Carpenters Regional Council of the United Brotherhood of Carpenters and Joiners of America and affiliated local Unions as identified in the Trust Agreement.

Urgent/Immediate Care Facilities and Retail Clinics
"Urgent/Immediate Care Facilities" means a licensed facility outside of a Hospital Emergency Room, primarily engaged in providing minor Emergency and episodic medical care to its patients. A Physician, RN and a registered X-ray technician must be in attendance at all times when the facility is open. The urgent/immediate care facility must include X-ray and laboratory equipment and a life-support system. A "Retail Clinic" means a licensed facility primarily engaged in treatment of uncomplicated minor illnesses and may provide preventive health care services. A nurse practitioner or Physician's assistant must be in attendance at all times when the Retail Clinic is open.

USERRA
USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994 (including any amendments to such Act and any interpretive regulations or rulings).

Utilization Review
"Utilization Review" means a process to determine whether certain health care services are Medically Necessary, appropriate, provided at a reasonable location and/or are cost-effective.

Work-Related
For a definition of "Work-Related," see the definition of "Occupational or Work-Related Illness or Injury" on page 118.

