

SOUTHWEST CARPENTERS HEALTH AND WELFARE TRUST

Summary Plan Description (SPD)
and Plan Document for Active
Carpenters with Information
about Your Medical, Dental,
Vision, Life, Disability and
General Plan Information



CARPENTERS' HEALTH TOOLBOX

BUILDING BETTER HEALTH

JANUARY 1, 2019

Southwest Carpenters Health and Welfare Trust
Summary Plan Description/Plan Document

**Describing the
Health Care Benefits, Disability Benefits, Life Insurance, and
Accidental Death and Dismemberment Insurance
For
Eligible Active Carpenters and their Eligible Dependents**

Restated as of January 1, 2019

SOUTHWEST CARPENTERS HEALTH AND WELFARE TRUST

TRUST ADMINISTRATIVE OFFICE

Carpenters Southwest Administrative Corporation
533 South Fremont Avenue
Los Angeles, CA 90071-1706

www.carpenterssw.org

(213) 386-8590 or (800) 293-1370

The Plan described in this document is restated and **effective January 1, 2019**, except for those provisions that specifically indicate other effective dates, and this document replaces all other Summary Plan Descriptions (SPD)/Plan Documents previously provided to you. All changes adopted since the last SPD dated April 1, 2016 have been incorporated, including all amendments to the Plan through and including Amendment No. 2018-3.



SOUTHWEST CARPENTERS HEALTH AND WELFARE TRUST

Administrative Office (Headquarters)
533 South Fremont Avenue
Los Angeles, CA 90071-1706

Dear Active Carpenter Participants and Beneficiaries,

The Board of Trustees (the “Board”) of the Southwest Carpenters Health and Welfare Trust (the “Trust”) is appointed in equal numbers by the Southwest Regional Council of Carpenters (“SWRCC” or the “Union”) and Employers signatory to Collective Bargaining Agreements with affiliates of SWRCC. The Trust sponsors the Southwest Carpenters Health and Welfare Plan for Active Carpenters (the “Plan”), as restated from time to time, to provide benefits to eligible actively employed Carpenters and their eligible beneficiaries in Southern California, Nevada, Arizona, Utah, New Mexico, Colorado, Wyoming and portions of west Texas.

The Plan provides medical and prescription benefits to you and your eligible Dependents in the form of medical plan options in which you may enroll if you meet the Plan’s eligibility requirements. There is an insured Health Maintenance Organization (HMO) called the Kaiser Deductible HMO Medical plan, and an Anthem Medical PPO Plan that is funded directly by the Trust and which uses a Preferred Provider Organization (PPO) network.

Insured Dental Plan options are also provided, including a Select Managed Care Direct Compensation (DC) Dental Plan, Dental Preferred Provider Organization (DPPO) Plan, and an In-Network Only (INO) Dental Plan.

This booklet contains a description of the benefits under the Anthem Medical PPO Plan as well as additional welfare benefits. The Plan provides certain self-funded long term disability benefits, life insurance for employees and Dependents, employee accidental death and dismemberment insurance, an insured Vision Plan, and other welfare benefits as described in this booklet.

This booklet describes the Plan’s eligibility rules and benefits for Active Carpenters in SWRCC bargaining units and their families effective as of **January 1, 2019**. It also describes the Plan eligibility rules and benefits for certain related Special Class Employees, whose employers have adopted the Plan, but who are not members of SWRCC bargaining units. Chapter 3 describes when you are eligible for the Plan.

Medical benefits provided under the Plan through the insured Kaiser Deductible HMO Medical Plan are summarized in a separate booklet issued by the HMO Medical Plan, upon your enrollment. The insured Dental Plan Options, as well as the Vision Plan, are summarized in chapters in this document with more information available directly from the Dental and Vision insurance companies.

If you have enrolled in the Kaiser Deductible HMO Medical Plan and/or a Dental Option or the Vision Plan and have not received a booklet from that HMO Medical, Dental, or Vision insurance carrier, you may go online to view the benefit booklet, or you may request another booklet from the HMO Medical, Dental, or Vision insurance carriers by calling them, going online, or by written correspondence. See the Quick Reference Chart in the front of this document for contact

information for these insurance carriers.

State laws apply to the insured HMO Medical Plan, Dental Plan options, Vision Plan, and Life and AD&D insurance benefits, but generally State laws do not apply to the self-funded Anthem Medical PPO Plan or to the self-funded Long Term Disability benefits. Chapters 4, 5 and 6 contain comprehensive information on the services covered under the Anthem Medical PPO Plan.

To maximize the benefits of the Plan, we urge you to familiarize yourself with this booklet before the need for care arises.

The Board and providers of managed care under the Plan have the right to amend the Plan and/or health care options, including to modify benefits, and will notify you of changes by providing you with inserts to this booklet. You should keep the inserts describing material modifications with this booklet.

If you have questions about this Summary Plan Description/Plan Document, or need assistance not provided by the claims administrators or managed care providers under the Plan, please contact the Administrative Office, where the staff will be happy to assist you.

Este documento contiene una breve descripción sobre sus derechos de beneficios del plan, en Inglés. Si usted tiene dificultad en comprender cualquier parte de este documento, por favor de ponerse en contacto con la Oficina Administrativa a la dirección y teléfono en el Quick Reference Chart de este documento.

Sincerely,

BOARD OF TRUSTEES

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Chapter 1: QUICK REFERENCE CHART

This Chapter includes information on:

- **Companies and individuals who can help you understand the Plan's benefits, process your claims, and answer questions. The Quick Reference Chart includes the contact name along with the contact phone numbers and websites.**

QUICK REFERENCE CHART	
Information Needed	Whom to Contact
<p>ADMINISTRATIVE OFFICE</p> <ul style="list-style-type: none"> • Questions about eligibility or general information • Replacement of ID cards • MemberXG portal: the way you and your Dependents can access personalized benefit information 24/7 via a secure portal using your computer, tablet or smartphone. You can check topics like: eligibility, work history, vacation payments, pension credits, your beneficiary designation for life insurance, etc. • Questions about Life Insurance or Accidental Death and Dismemberment benefits • Life Insurance Beneficiary Designation form (available on the Trust's website) • Questions about the Disability Hours Credit program • Questions about Long Term Disability (LTD) Benefits • Questions about the Hours Buy Back provision (self-payment for shortage of work hours) • COBRA administrator: questions about COBRA, COBRA premium payments, and COBRA administration • HIPAA Privacy Notice, Privacy & Security Officers • Medicare Part D Creditable Coverage notice and other required notices • Summary of Benefits and Coverage (SBC) documents 	<p>Carpenters Southwest Administrative Corporation ("CSAC")</p> <p>(213) 386-8590 or toll-free (800) 293-1370 (M-F 8:00am to 5:00pm PT)</p> <p>Address: 533 South Fremont Avenue Los Angeles, CA 90071-1706</p> <p>Call or visit the Fund's website: www.carpenterssw.org</p> <p>To sign up for Member XG, or log into the Member XG portal, go to bit.ly/MemberXG-CSAC</p>

QUICK REFERENCE CHART	
Information Needed	Whom to Contact
ANTHEM MEDICAL PPO PLAN For more information about the Anthem Medical PPO Plan, see Chapters 4, 5 and 6.	
ANTHEM MEDICAL PPO PLAN: NETWORK, CLAIMS ADMINISTRATION, AND MEMBER SERVICES <ul style="list-style-type: none"> • Medical Network Provider Directory (no charge) • Additions/Deletions of Network Providers. Always check with the Network before you visit a provider to be sure they are still contracted and will give you the discounted price. • Anthem In-Network Providers include: <ul style="list-style-type: none"> • the “Prudent Buyer PPO Network” in California which contains participating and contracted providers along with certain Centers of Excellence facilities and Blue Distinction Centers of Specialty Care (Hospitals and health care facilities that provide high quality care for certain procedures.) • the Anthem BCBS network in Colorado • the BlueCard Program to access participating providers in other geographical areas of the U.S. • Member Services Support: to answer questions about medical benefits, claims and appeals, ID card replacement, Coordination of Benefits, etc. • 24/7 NurseLine: If you, your Dependent gets sick or injured when your doctor’s office is closed, you can call the Anthem 24/7 NurseLine. The call is free to you. Registered nurses are ready and waiting to help you – over the phone – with your health concerns. If you need an interpreter, the 24/7 NurseLine can help you in a language you understand. • Future Mom’s Program: an Anthem program that helps mothers-to-be have healthier pregnancies and longer-term babies. Through individualized nurse interventions, expectant members learn about prenatal care, the prevention of preterm labor and how to best follow their Physician’s plan of care. • Anthem Health Guide: when you need help finding an in-network doctor, need help coordinating care, want to understand what is covered, etc. 	Anthem <p>For Member Services, 24/7 NurseLine, and questions about any of the Anthem programs, call the number on your ID card or (833) 224-6930.</p> <p>To locate a preferred provider in the Anthem Prudent Buyer network (at no cost to you) call (833) 224-6930, or go to the “Find a Doctor” function on www.anthem.com/ca</p> <p>Anthem Medical PPO Plan Claims Address: Anthem Blue Cross Prudent Buyer Plan P.O. Box 60007 Los Angeles, CA 90060-0007</p> <p>The BlueCard Program allows a member in the U.S., who is outside of California, to have the use of a participating provider contracted under other states’ Blue Cross and/or Blue Shield licensees. If you are outside California, call the toll-free BlueCard Provider Access number on your ID card.</p> <p>Claims from a Foreign Country: If you obtained health care outside the U.S. that may be reimbursed by the Anthem Medical PPO Plan, the BlueCross BlueShield Global Core Service Center will process that claim. Claim forms and information is available from their website at www.bcbsglobalcore.com or call toll-free to 800-810-2583.</p> <p>Go to the App Store or Google Play and download the “Anthem BC Anywhere” app to find a doctor, check your claims, view the cost estimator tool, access the 24/7 Nurseline or video visits, and more.</p>

QUICK REFERENCE CHART

Information Needed	Whom to Contact
<p>ANTHEM MEDICAL PPO PLAN: TELEHEALTH VISIT</p> <p>For Anthem Medical PPO Plan participants, an online visit with a health care professional via video live chat, called LiveHealth Online, is available 24 hours/day, 7 days/week for \$5.00 per visit (Deductible does not apply).</p> <ul style="list-style-type: none"> • It's affordable convenient care whether you have a cold, you're feeling anxious or need help managing your medication, doctors and mental health professionals are ready to help you feel better. • Using LiveHealth Online you can have a video visit with a board-certified doctor, psychiatrist, or licensed therapist from your smartphone, tablet or computer from home or anywhere. • This Plan provides benefits for covered services through telehealth. Telehealth is a consultation between a patient and a provider. A telehealth visit is highly useful but limited to the extent a comprehensive personal examination is needed. • "Telehealth" is the means of providing health care services using information and communication technologies in the consultation, diagnosis, treatment, education, and management of the patient's health care when the patient is located at a distance from the health care provider. • Telehealth does not include consultations between the patient and the health care provider, or between health care providers, by telephone, facsimile machine, or electronic mail. 	<p>LiveHealth Online (888) 548-3432</p> <p>To use this electronic visit service you must sign up online (it's free to sign up) at www.livehealthonline.com. See also the Frequently Asked Questions on this website for more information.</p> <p>Download the Mobile App for free, for your smartphone or tablet, from iTunes Apple.com or Google Play at play.google.com/store (search for Mobile Health Consumer) or, go to mobilehealthconsumer.com and choose the User button in the top right corner, then select Register Now.</p> <p>For the best experience when using LiveHealth Online app on your Android or iOS device, a Wi-Fi connection is recommended.</p> <p>Email and customer support is available from customersupport@livehealthonline.com or call toll-free (888) 548-3432.</p>

QUICK REFERENCE CHART	
Information Needed	Whom to Contact
<p>ANTHEM MEDICAL PPO PLAN: PREAUTHORIZATION PROGRAM</p> <ul style="list-style-type: none"> (Note: an Emergency admission does not require preauthorization, just provide notice of the admission to Anthem within 24 hours of the admission or as soon as possible within a reasonable period of time.) 	<p>For preauthorization call AIM Specialty Health toll-free at 1-877-291-0360.</p> <p>For preauthorization of specialty Drugs not obtained through Accredo Specialty Pharmacy, Physician to call 1-800-987-4904 or fax prescription to 1-800-391-9707. Members can call 1-800-803-2523.</p> <p>Mail preauthorization request to: Anthem Blue Cross Preauthorization Department 2000 Corporate Center Drive CANPA-000 Newbury Park, CA 91320</p>
<p>ANTHEM MEDICAL PPO PLAN: OUTPATIENT PRESCRIPTION DRUGS</p> <ul style="list-style-type: none"> Questions about Retail, Mail Order and Specialty Prescription Drugs Specialty Drugs Preauthorization of certain outpatient Prescription Drugs Information about the Preferred Drug Formulary, step therapy, and quantity limits Direct Member Reimbursement (DMR) 	<p>Express Scripts Inc (ESI) (The Plan's Pharmacy Benefit Manager – PBM) Toll-free (800) 987-7836 Call or visit the ESI website: www.express-scripts.com/</p> <p>You can manage your prescriptions online, order refills, get tips on how to save money, check order status, transfer prescription from retail to mail order, check on Drug interactions, etc. using the Express Scripts app available from App Store or Google Play.</p> <p>For all Drug preauthorization, Physicians can call 1-800-753-2851.</p> <p>For Specialty medication questions, call Accredo Specialty Pharmacy at 1-800-803-2523.</p>
<p>VISION COVERAGE (insured). For more information about this Vision Plan, see Chapter 8, or contact UHC.</p>	
<ul style="list-style-type: none"> Vision Plan (an insured Vision Plan) 	<p>UnitedHealthcare (UHC) Vision (800) 638-3120 To locate in-network vision providers: www.myuhcvision.com or call (800) 839-3242.</p>

QUICK REFERENCE CHART	
Information Needed	Whom to Contact
<p>HMO MEDICAL PLAN OPTIONS (insured). For more information about the HMO plans, refer to the booklets from Kaiser, contact Kaiser, or visit the Fund’s website at: https://carpenterssw.org/media/2293/2019-kaiser-evidence-of-coverage.pdf</p>	
<ul style="list-style-type: none"> • Kaiser Deductible HMO Medical Plan – California Includes outpatient Prescription Drugs through Kaiser. • ID cards 	<p>Toll-free (800) 464-4000</p> <p>Call or visit the website: www.kp.org</p>
<ul style="list-style-type: none"> • Kaiser Deductible HMO Medical Plan – Colorado Includes outpatient Prescription Drugs through Kaiser. • ID cards 	<p>Toll-free (800) 639-8657</p> <p>Denver / Boulder 1-303-338-3800 Mountain Region 1-844-837-6884 Southern CO Region 1-888-681-7878 Northern CO Region 1-844-201-5824</p> <p>Call or visit the website: www.kp.org/</p>

QUICK REFERENCE CHART	
Information Needed	Whom to Contact
DENTAL COVERAGE (insured). For more information about these Dental Plans, see Chapter 7, refer to the dental booklets from UHC or contact UHC.	
<ul style="list-style-type: none"> • Dental Preferred Provider Organization (DPPO) Plan (an insured Dental Plan with in-network and non-network providers available in all states) • ID cards 	<p>UnitedHealthcare (UHC) Phone: (800) 445-9090 Website to locate in-network providers: www.welcometouhc.com/csac and search the CSAC PPO network</p>
<ul style="list-style-type: none"> • Select Managed Care Direct Compensation (DC) Dental Plan (an insured Dental Plan) • ID cards 	<p>UnitedHealthcare (UHC) Phone: (800) 445-9090 Website to locate in-network providers: www.welcometouhc.com/csac For California residents, search the CSAC CA DC network. For Nevada residents, search the CSAC NV DC network</p>
<ul style="list-style-type: none"> • In-Network Only (INO) Dental Plan (an insured Copayment Dental Plan with in-network providers only) • ID cards 	<p>UnitedHealthcare (UHC) Phone: (800) 445-9090 Website to locate in-network providers: www.welcometouhc.com/csac and search the CSAC INO network</p>
LIFE INSURANCE, ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE (insured). For more information about Life and AD&D insurance, see Chapters 11, 12 and 13 or contact MetLife.	
<ul style="list-style-type: none"> • Life Insurance for employees and Dependents • Accidental Death and Dismemberment Insurance (AD&D) for employees only 	<p>MetLife (also known as Metropolitan Life Insurance Company) Contact phone number and address is: Carpenters Southwest Administrative Corporation (“CSAC”) 533 South Fremont Avenue Los Angeles, CA 90071-1706</p> <p>(213) 386-8590 or toll-free (800) 293-1370</p> <p>To complete a form to designate a Beneficiary for life insurance purposes, visit this site: http://carpenterssw.org/media/1006/beneficiary-form-new.pdf</p>

Chapter 2: OVERVIEW

This Chapter includes information on:

- The value of the SPD/Plan document
- Helpful reminders
- Overview of Eligibility for the Plan
- Overview of Benefit Options under the Plan
- How to File a Claim

This Summary Plan Description (SPD)/Plan Document describes the medical, dental, vision, long term disability, life insurance and accidental death and dismemberment benefits of the Southwest Carpenters Health and Welfare Trust (the “Trust”).

The Plan described in this document is **effective January 1, 2019** and replaces all other health and welfare Plan documents, summary Plan descriptions and applicable amendments to those documents previously provided to Plan participants.

- To determine if you are in a class of individuals who are eligible for benefits under this Plan, refer to the Eligibility chapter in this document. Coverage for eligible Dependents will be conditioned on you providing satisfactory proof of Dependent status to the Plan.
- Note that your eligibility or right to benefits under this Plan should not be interpreted as a guarantee of employment. Receipt of this document does not guarantee eligibility for Plan benefits.
- No individual shall have accrued or vested rights to benefits under this Plan. A vested right refers to a benefit that an individual has earned the right to receive and that cannot be forfeited. Plan benefits are not vested and are not guaranteed.

This document will help you understand and use the benefits provided by Southwest Carpenters Health and Welfare Trust. You should review it and share it with those members of your family who are or will be covered by the Plan. It will give all of you an understanding of the coverages provided; the procedures to follow in submitting claims; and your responsibilities to provide necessary information to the Plan. Be sure to read the Exclusions and Glossary Chapters.

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

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

This Plan is established under and subject to the federal law, Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA.

- The Anthem Medical PPO Plan and long term disability benefits of the Plan are self-funded with contributions from the Fund, Eligible Employers and self-payment participants held in a Trust which is used to pay Plan benefits. Independent Claims Administrators (whose names are listed on the Quick Reference Chart in this document) pay benefits out of Trust assets.

- The HMO medical plan, dental plans, vision plan, life insurance and accidental death and dismemberment benefits of the Plan are fully insured with insurance companies, whose names are listed on the Quick Reference Chart in this document.

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

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

For a more complete description of eligibility requirements and Plan benefits for the Anthem Medical PPO Plan and the Long Term Disability benefits, please refer to the chapters of this booklet named in the preceding Table of Contents.

If you are enrolled in an insured HMO Medical Plan, Vision Plan, Dental Plan Option or Life Insurance, please refer to the benefit booklet(s) issued by the HMO Medical Plan, Vision Plan, Dental Plan Option or Life Insurance carrier for details about your Plan. This document may only provide a very brief outline about the insured benefits so you should rely on the official documents available from the appropriate insurance company.

NOTE: Certain terms used in this document have a precise meaning (for example, “Medically Necessary”, “Emergency” or “Experimental”). To be sure you understand the meaning of certain terms used in this document, please refer to the Glossary Chapter of this booklet.

Language Translation Support

If you do not understand English, contact the Administrative Office to find out if assistance is available. See the Quick Reference Chart for contact information.

- **SPANISH (Español):** Para obtener asistencia en Español, llame al (213) 386-8590 or toll-free (800) 293-1370.
- **TAGALOG (Tagalog):** Kung kailangan niyo ang tulong sa Tagalog tumawag sa (213) 386-8590 or toll-free (800) 293-1370.
- **CHINESE (中文):** 如果需要中文的帮助, 请拨打这个号码 (213) 386-8590 or toll-free (800) 293-1370.
- **NAVAJO (Dine):** Dinek’ehgo shika at’ohwol ninisingo, kwijigo holne’ (213) 386-8590 or toll-free (800) 293-1370.

Questions You May Have

If you have any questions concerning eligibility or the benefits that you or your family are eligible to receive, please contact the Administrative Office, at their phone number and address located on the Quick Reference Chart in this document.

As a courtesy to you, the staff of the Administrative Office, and other vendors subcontracted to the Fund to assist in Plan administration duties, may respond informally to oral questions; however, oral communications are not binding on the Plan and cannot be relied upon in any dispute concerning your benefits. Your most reliable method is to put your questions into writing and fax or mail those questions to the Administrative Office and obtain a written response from the Administrative Office.

In the event of any discrepancy between any information that you receive from the Administrative Office, orally or in writing, and the terms of this document, the terms of this document will govern your entitlement to benefits, if any.

For Help Or Information

When you need information, please check this document first. If you need further help, call the individuals listed in the following Quick Reference Chart in Chapter 1.

Authorized Sources of Information

The only authoritative sources of information about the Plan are:

- this Summary Plan Description/Plan Document (also referred to as “this booklet”), the HMO Medical Plan or other insurance company documents, and/or subsequent booklet inserts (if any);
- the Trust Agreement;
- the administrative service or insurance agreements between the Trust and HMO Medical Plan, Dental Plan Options, Vision Plan, Life Insurance, and other managed care, health and welfare benefit coverage providers, as in effect at applicable times;
- written statements issued by the Administrative Office or Claims Administrator on behalf of the Plan on Carpenters Southwest Administrative Corporation letterhead or Anthem Blue Cross letterhead; and
- the written statements of duly Authorized Representatives of the insured HMO Medical Plan, Dental Plan Options, Vision Plan, Life Insurance, or other managed care, health and welfare benefit providers contracting with the Trust at applicable times (but only with respect to benefits provided by such providers).

Statements or representations made in documents or by entities or individuals other than those described above (including Union or Employer entities) are not authoritative sources of information, and should not be relied upon. If you cannot find the information about the Plan that you need, contact the Administrative Office for information about the Plan.

A copy of the Trust Agreement and the SPD/Plan Document may be reviewed at the Administrative Office at the address above during normal business hours or at your Local Union’s Office during normal business hours. You may obtain a copy of the Trust Agreement and/or SPD/Plan Document, for a reasonable copying charge, by writing to the Administrative Office, whose contact information is listed on the Quick Reference Chart in the front of this document.

Filing Claims

Information on how to file claims may be outlined at the end of a Chapter describing individual benefits. For more information on how to file a claim and what to do if you disagree with a decision made about your claim (how to appeal), see the Chapter on “Claim Filing and Claim Appeals.”

IMPORTANT NOTICE

You or your Dependents must promptly furnish to the Administrative Office information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, birth and change in status of a Dependent Child, Medicare enrollment or disenrollment, an individual no longer meeting the eligibility provisions of the Plan, or the existence of other coverage. Proof of legal documentation will be required for certain changes.

Notify the Plan of any of these changes within 31 days. Note that for certain changes, like divorce or a child reaching the limiting age, if you do not notify the Plan within 60 days of that change, the opportunity to elect COBRA will not apply.

Failure to give the Administrative Office a timely notice of the above noted events may:

- a. cause you, your Spouse and/or Dependent Child(ren) to lose the right to obtain COBRA Continuation Coverage,
- b. cause coverage of a Dependent Child to end when it otherwise might continue because of a disability,
- c. cause claims to not be considered for payment until eligibility issues have been resolved,
- d. result in your liability to repay the Plan if any benefits are paid to an ineligible person. The Plan also has the right to offset the amounts paid against the participant's future health benefits.

Overview of Eligibility

Overview of Eligibility See Chapter 3 for more information on Eligibility provisions.	
Type of Participant	Eligibility Requirement
Active Carpenter	Submit your properly completed enrollment forms when due, and have 360 Hours Worked and reported (or drawn from your reserve bank) in the Work Quarter (January 1 through March 31, April 1 through June 30, July 1 through September 30 or October 1 through December 31) ended immediately preceding the Eligibility Quarter (February 1 through April 30, May 1 through July 31, August 1 through October 31 and November 1 through January 31) during which you will then be eligible for Plan benefits. Special rule for first time eligible Employees- The number of work hours required for initial eligibility by participants that have never been covered under the Plan is 300 hours in a Work Quarter. After initial eligibility is established, the work hour requirement will revert to the normal 360 hours for any subsequent Eligibility Quarter.

Overview of Eligibility See Chapter 3 for more information on Eligibility provisions.	
Non-bargaining Unit Employee	Submit your properly completed enrollment forms when due, and be a member of a group employed by a Southwest Regional Council of Carpenters (SWRCC) – related employer who is eligible for, and contributing to, the Plan on your behalf. In most cases, you will commence participation in the Plan on the first day of the first calendar month following 30 consecutive days of full time employment in such a group.
Dependents	Must be listed on the enrollment forms and proof of dependency documentation must be submitted when due (including upon subsequent request). Dependents are generally eligible during the period that the participant to whom they are related is eligible. Special rules may apply to Dependents of non-bargaining unit participants. Your newly acquired Dependent must be properly enrolled within 31 days following the date you acquired the Dependent, in order to be eligible for Plan benefits.

Overview of Medical, Dental, Vision, LTD, Life Insurance and AD&D Insurance Benefits

Overview of Medical, Dental, Vision, Long Term Disability (LTD), Life Insurance and AD&D Insurance Benefits	
Benefit	Description
Medical Plan Options (eligible Dependents can only be enrolled under the benefit option that covers the Active Carpenter or Special Class Employee)	Eligible employees may select a Medical Plan (which includes outpatient Prescription Drug benefits), based on the state in which they live: In California and Colorado <ul style="list-style-type: none"> • Anthem Medical PPO Plan (using the Anthem network) • Kaiser Deductible HMO Medical Plan In Arizona, Nevada, New Mexico, Utah, Texas, Wyoming, and all other states <ul style="list-style-type: none"> • Anthem Medical PPO Plan (using the Anthem network) See Chapters 4, 5 and 6 for more information on Anthem Medical PPO Plan benefits.
Dental Plan Options	Eligible employees may select a Dental Plan, based on the state in which they live: In California and Nevada <ul style="list-style-type: none"> • UnitedHealthcare Select Managed Care Direct Compensation (DC) Dental Plan • UnitedHealthcare Dental Preferred Provider Organization (DPPO) Plan In New Mexico and Texas <ul style="list-style-type: none"> • UnitedHealthcare Dental Preferred Provider Organization (DPPO) Plan In Arizona, Colorado, Utah, Wyoming and all other states <ul style="list-style-type: none"> • UnitedHealthcare In-Network Only (INO) Dental Plan • UnitedHealthcare Dental Preferred Provider Organization (DPPO) Plan See Chapter 7 for more information on dental plan benefits.

Overview of Medical, Dental, Vision, Long Term Disability (LTD), Life Insurance and AD&D Insurance Benefits	
Benefit	Description
Vision Plan	<p>Vision coverage is provided by UnitedHealthcare Vision</p> <ul style="list-style-type: none"> • In-network: \$10 Copay for eye exam, \$20 Copay for vision materials. • Out-of-network: You can be reimbursed up to the scheduled allowances. • Eye exam and lenses available once every 12 months and frame available once every 24 months. • Contact lenses instead of frames and lenses (\$20 Copay) available once every 12 months. <p>See Chapter 8 for more information on vision plan benefits.</p>
Disability Hours Credit benefit	<p>Effective for disabilities occurring on or after January 1, 2019, if an Active Carpenter becomes Disabled in a Work Quarter, the Active Carpenter will be credited in that Work Quarter and the immediately following Work Quarter, with disability hours at the rate of eight (8) hours each day the Active Carpenter is Disabled (excluding Saturdays, Sundays and holidays). These provision are explained in more detail in Chapter 3.</p>
Long term monthly disability (LTD) benefit	<p>For Totally Disabled employees who meet specific eligibility requirements. Provides a monthly benefit amount to an Eligible Individual during disability, through the earlier of normal retirement age or commencement of a pension under the Southwest Carpenters Pension Plan, (that is calculated based upon vested pension credits earned under the Pension Plan and which differs depending on marital status and other factors).</p> <p>See Chapter 10 for more information on LTD benefits.</p>
Hours Buy Back Option	<p>The self-payment (hours buy back) provision allows an employee to make a payment to the Fund for the difference in their hour bank balance and one quarter of eligibility. The self-payment will then allow the employee to maintain eligibility for this additional quarter (when that employee would have otherwise lost eligibility). These provisions are explained in more detail in Chapter 3.</p>
Life insurance on the life of:	<ul style="list-style-type: none"> • Employee: \$20,000 coverage • Spouse: \$3,000 coverage • Children: \$3,000 coverage each <p>See Chapters 11 and 12 for more information on Life insurance benefits.</p>
Accidental death and dismemberment insurance (AD&D) (employees only)	<ul style="list-style-type: none"> • Up to \$20,000 coverage for the employee, depending on the type of loss. <p>See Chapter 13 for more information on AD&D insurance benefits.</p>

HOW CAN I BE A WISE CONSUMER OF HEALTH CARE AND GET THE MOST VALUE OUT OF MY ANTHEM MEDICAL PPO PLAN?

- ✓ **Use Network (PPO) providers.** They charge less, and you pay less. In addition, Preventive Care is free when provided by Network PPO providers. Refer to the Quick Reference Chart in the front of this document for contact information.
- ✓ **Choose Generic Drugs when possible. Using the Mail Order Service for maintenance Drugs is required after two refills at a Retail Pharmacy.**

Ask your Doctor or Dentist if a Generic Drug is appropriate for you. You'll pay less for generic Drugs than for brand name Drugs in most situations.

The generic Drug name of a Drug is its chemical name. A brand Drug name is a trade name under which the Drug is advertised. In general, a generic Drug will be dispensed if available unless you or the prescribing Physician or Dentist indicates that no substitution is to be made. In such a case, your cost will be the brand name Copay plus the difference in cost between the Drug actually dispensed and its generic Drug equivalent.

Filling your medication through the Mail Order Service is a cost-effective way to obtain a 90-day Drug supply. After two refills of maintenance Drugs at a Retail Pharmacy, you are required to use the Mail Order Service.
- ✓ **Have a chronic health condition like diabetes, asthma, arthritis, heart disease, high cholesterol, etc.?** One of the best things you can do for that condition is to take the medication your Doctor recommends for you. **Make medication compliance your habit to a healthier life.** Anthem has a 24/7 Nurse line, Future Mom's program, Anthem Health Guide, and more. For Anthem's contact information, see the Quick Reference Chart in the front of this document.
- ✓ **Keep current with your Preventive/Wellness care** to help identify any health risk factors (like high blood pressure, high blood sugar, weight creeping above the recommended range). Get tips from your provider on how to reduce your health risks, and stay current on recommended immunizations and cancer screening tests.
- ✓ **Not feeling well?** Call your Network Doctor's office for help. Or, use the Telemedicine virtual office visit service (contact information on the Quick Reference Chart), or go to a Network Urgent Care facility instead of an Emergency Room (ER), if medically appropriate.
- ✓ **Preauthorize** certain Anthem Medical PPO Plan services and certain outpatient Drugs to help avoid a financial penalty, as explained in Chapter 4.
- ✓ **Review Your Healthcare Bills.** If something on a bill just doesn't look right, contact the Medical, Dental or Vision Plan Claims Administrator if you think there might be an error.

These tips will help you make the most of the Anthem Medical PPO Plan's benefits.

For additional resources visit: www.carpenterssw.org.

Chapter 3: ELIGIBILITY, ENROLLMENT, DISABILITY HOURS CREDITS, SELF-PAYMENT HOURS BUY BACK PROVISION, TERMINATION, AND COBRA CONTINUATION COVERAGE

This Chapter includes information on:

- Eligibility including the Hours Buy Back Provision
- Enrollment: Initial Enrollment, Special Enrollment, Open Enrollment
- Coverage during family or medical leave (FMLA)
- Coverage during Military Leave (USERRA)
- When eligibility terminates
- COBRA continuation coverage

The eligibility rules described in this booklet apply to all the benefits provided under the Plan to employees and their Dependents, including the Kaiser Deductible HMO Medical Plan, and Anthem Medical PPO Plan, the Dental Plan options, and the Vision Plan.

As long as you are an employee who is eligible for coverage under the Plan, then you and your Dependents will automatically be covered under the medical plan and vision plan (and the employee may also elect a Dental Plan). The employee will also be covered under the life insurance benefit, and the accidental death and dismemberment benefit. Eligibility for the Long Term Disability benefit is discussed in Chapter 10.

Who Is Eligible

IMPORTANT: If you are establishing **initial eligibility** you must submit properly completed enrollment forms along with documentation on your Dependents to the Administrative Office **within 31 days**. Otherwise, your health care coverage effective date will be delayed until the first day of the month in which the Administrative Office receives your completed forms and documentation.

Eligible Individuals

The rules below explain when Active Carpenters, Special Class Employees and their Dependents are eligible to receive Plan benefits. During the time a person is eligible to receive Plan benefits (which usually is measured in **Eligibility Quarters**) that person is an “Eligible Individual,” that is, a participant or beneficiary of the Plan. You have rights under the Plan only with respect to the times you are an Eligible Individual and therefore it is important that you know when you and your Dependents are Eligible Individuals. This subject is usually referred to as “eligibility” when you are talking with the Administrative Office.

An Active Carpenter will be an Eligible Individual beginning on the first day of an Eligibility Quarter, and continuing through the last day of such Eligibility Quarter (provided the status as an Eligible Individual is not earlier terminated) whenever the sum of:

- a. the Hours Worked by the Active Carpenter during the Work Quarter ended immediately preceding the commencement of such Eligibility Quarter, and

- b. the number of Hours Worked in the Active Carpenter’s Reserve Account as of the last day of such Work Quarter, equals or exceeds 360 for any Eligibility Quarter. However, “300” shall be substituted for “360” in the prior sentence in the case of a first-time Participant’s initial Eligibility Quarter.

Active Carpenters Eligibility

To establish eligibility and become an Eligible Individual during an Eligibility Quarter, you must work for Contributing Employers for at least **360 hours** in the immediately preceding **Work Quarter** as follows:

WORK QUARTER	ELIGIBILITY QUARTER
If you work 360 hours during the months of:	You have coverage during the next following months of:
January, February, March	May, June, July
April, May, June	August, September, October
July, August, September	November, December, January
October, November, December	February, March, April

Special Rule for First Time Participants

The number of work hours required for **initial eligibility** by employees that have never been covered under the Active Plan will be **300 hours** in a Work Quarter. After initial eligibility has been established, the work hour requirement will revert to the **normal 360 hours for any subsequent Eligibility Quarter**.

Important Note on Retroactive Coverage Effective Dates for Active Carpenters

Retroactive coverage effective dates will only be granted if an eligibility determination by the Administrative Office is delayed because of **late reported hours**, including reciprocity hours. In such circumstance, coverage may be **retroactive for up to 90 days, provided the Active Carpenter submits the required completed enrollment forms** to the Administrative Office within **31 days**. It is important that you submit the required enrollment forms and documentation on a timely basis to avoid a gap in your health coverage.

Reserve Bank/Reserve Account (applicable to Active Carpenters only)

Reserve Account means the account established for an Active Carpenter to accumulate Hours Worked in a Work Quarter in excess of the minimum required for eligibility. If you work more than **360 hours** during a Work Quarter (or more than 300 hours for first time participants qualifying under the Special Rule described above), the **excess hours will be credited to a reserve account** (sometimes called a “bank”) established for you, up to a **reserve account maximum of 720 hours**.

You will be eligible during an Eligibility Quarter whenever the Hours Worked by you (if any) in the Work Quarter ending immediately prior to such Eligibility Quarter, plus the hours in your reserve account, total at least **360 hours**. Your reserve account must be applied in this manner and is reduced by any hours used to meet the 360-hour requirement.

There are certain conditions that will result in the **cancellation of all hours credited to your reserve account**. All reserve account hours **will be cancelled**:

- a. as of the last day of the second consecutive Eligibility Quarter during which you were not, in either such Eligibility Quarter, eligible for coverage under the Plan;
- b. immediately, if you knowingly perform work of the type which is covered by any Collective Bargaining Agreement, outside the coverage of a Collective Bargaining Agreement, while knowing that work covered by a Collective Bargaining Agreement is available;
- c. immediately, if you knowingly allow a Contributing Employer to under-report or over-report to the Administrative Office, or as such reporting is otherwise required by the applicable Collective Bargaining Agreement, Hours Worked by you.

If your work hours are divided between work for Contributing Employers under this Trust and work for Contributing Employers under other trusts, see the “Reciprocity” section below.

Certain Collective Bargaining Agreements (CBAs) require contributions to the Plan after an employee has attained a specified level in the CBA. Effective July 1, 2018, eligibility and benefit offerings of this Plan **will apply on the first Eligibility Quarter following employer contributions to this Plan**, subject to approval by the Board of Trustees or its Delegate. Any reserve bank balance will be counted toward eligibility and benefit offerings of this Plan.

Certain agreements allow these individuals to select the Bronze Plan. The opportunity to elect the Bronze Plan is only available during the Open Enrollment period. (The Bronze Plan is not described in this document. Contact the Administrative Office for information on the Bronze Plan.)

One-Time Supplement to Reserve Accounts

An Active Carpenter’s Reserve Account will be **increased by up to 200 Hours** Worked under the following conditions:

- a. The Active Carpenter is performing work for a Contributing Employer under a Collective Bargaining Agreement that specifies a maximum. Of thirty-five (35) or fewer hours per week on reported hours for which contributions are owed.
- b. The additional hours will be credited with the first Hour Worked under such Collective Bargaining Agreement on or after November 1, 2018.
- c. The additional hours will not cause the total hours in the Active Carpenter’s Reserve Account to exceed the maximum number of Hours Worked required for eligibility for two Eligibility Quarters.
- d. This provision will expire. As of October 31, 2019 unless the Board of Trustees approves an extension or renewal thereof. This provision is subject to approval by the Board of Trustees annually.

Alternate Eligibility Rules for Active Carpenters

Certain Collective Bargaining Agreements call for **immediate eligibility** (also called **instant eligibility**) in the Plan at the inception of such Agreements. If you have questions about whether such a Collective Bargaining Agreement applies to you, contact the Administrative Office.

If you perform work under such a Collective Bargaining Agreement, you will be eligible for benefits under the Plan on the first day of the month specified in the Collective Bargaining Agreement.

Requirements for eligibility are as follows:

- a. During your first month of coverage, your Contributing Employer must designate you as an Active Carpenter who customarily works at least the minimum number of hours set forth in the Collective Bargaining Agreement.
- b. All enrollment forms must be completed and submitted to the Administrative Office prior to coverage.
- c. You will be eligible for coverage during subsequent months only if you meet the requirements set forth in the Collective Bargaining Agreement.
- d. Once you have worked 360 or more hours in a Work Quarter (calendar quarters ended March 31, June 30, September 30, and December 31), you will need to meet the work-hour requirements in the chart at the start of “Active Carpenters” above to be eligible for benefits thereafter.

Commencement and Continuation of Eligibility of Active Carpenters under In Lieu Agreements

Immediate eligibility (also called instant eligibility) is permitted for employees whose employer is signatory to an **In Lieu Agreement** approved by the Benefits Committee of the Board which provides for such immediate eligibility in a manner consistent with the Plan’s provisions for alternate eligibility for Active Carpenters. If an Active Carpenter performs work under such an In Lieu Agreement and meets the requirements set forth therein for immediate eligibility in the Plan, such Active Carpenter shall become an Eligible Individual in accordance with this provision.

Such an Active Carpenter shall become an Eligible Individual on the first day of the first month specified in the In Lieu Agreement, or, if later, the first day of the first month which the Administrative Office and Benefits Committee deems administratively feasible.

The In Lieu Agreement shall conform with the following:

- a. Contributions will be at the rate specified in the approved In Lieu Agreement and shall be made for all Hours Worked for all members of the unit covered by the Collective Bargaining Agreement.
- b. In order to be an Eligible Individual with respect to a calendar month, the Active Carpenter shall, during the first month of coverage, have been designated by the Contributing Employer as an Active Carpenter who customarily works at least the minimum number of hours set forth in the Collective Bargaining Agreement for such Contributing Employer and the applicable monthly contribution for such Active Carpenter shall have been paid by the Contributing Employer in accordance with the applicable In Lieu Agreement.
- c. An Active Carpenter described in the foregoing Subsection on “Alternate Eligibility Rules for Active Carpenters” shall be an Eligible Individual for any month, and the first Eligibility Quarter commencing after immediate eligibility, if the Active Carpenter’s average Hours Worked per month (as determined by the Administrative Office in its discretion) equal or exceed the minimum Hours Worked as set forth in the approved In Lieu Agreement provided that, beginning with the first Work Quarter commencing immediately after such Active Carpenter’s initial month of eligibility, the Active Carpenter’s status as an Eligible Individual will be determined based on the normal standard for continuation of eligibility for purposes of the next succeeding Eligibility Quarter with the following modification: No excess hours are added to a Reserve Account until the Work Quarter that starts one year after immediate eligibility commences.

Immediate eligibility may be granted in accordance with alternate terms and conditions in lieu of the requirements set forth in paragraphs a.-c. above, which are set forth in sufficient detail in an In Lieu

Agreement approved by vote of the Board, or the Board's Benefits Committee, at a duly noticed and held meeting, and which are documented to the satisfaction of the Administrative Office, in its complete discretion.

Eligibility for a Newly Eligible Active Carpenter Apprentice

Certain Collective Bargaining Agreements (CBA) require contributions to the Active Employee Plan once an Active Carpenter Apprentice reaches a specified "level" (as defined in the CBA). Active Carpenter Apprentices indentured July 1, 2018 or later and who reach level 3, as well as a Foreman and other job titles addressed in the CBA, may be eligible for benefits under this Active Employee Plan.

If the employer is subject to a CBA containing a provision explained in the paragraph above, then eligibility for the benefit offerings of this Active Employee Plan apply with the **first Eligibility Quarter following employer's contributions to this Plan** (subject to the Trustees' approval).

Any reserve bank balance counts toward the eligibility and benefit offerings of the Active Employee Plan. When the Active Carpenter Apprentice reaches the specified level of eligibility, as defined in the CBA, the Active Carpenter Apprentice will receive additional information from the Administrative Office.

Note that certain CBAs allow Active Employee Apprentices to select the Bronze Plan. The opportunity to elect the Bronze Plan is only available during the Open Enrollment period. (The Bronze Plan is not described in this document. Contact the Administrative Office for information on the Bronze Plan.)

Apprentice Training Hours

If you are an apprentice that attends daytime JATC training classes in a Work Quarter (calendar quarters ended March 31, June 30, September 30, and December 31), you will be credited, in that Work Quarter, with training hours at the rate of eight (8) hours for each day you attend such training (excluding Saturdays and Sundays). The maximum training hours that can be credited during a Work Quarter is the sum of **360 hours** less any hours you actually worked for Contributing Employers and less any hours in your reserve account.

Reciprocity

Reciprocal agreements are in effect between this Trust and other trusts covering Carpenters in certain areas ("related plans"). Under the Reciprocal Agreements, it is possible for work covered by related plans to be considered together with work covered by this Trust, enabling a Carpenter to qualify for health and welfare benefits for which the Carpenter would be ineligible in the absence of such agreements. Reciprocal agreements permit a Carpenter to have portability and flexibility of their benefits when pursuing work across state lines.

This Trust became a party to the Health and Welfare Reciprocal Agreement Sponsored by the United Brotherhood of Carpenters and Joiners of America on July 1, 1989. This agreement permits the transfer of contributions from one health and welfare trust to another, which may enable the Carpenter to qualify for benefits. Under this Trust, the Carpenter is credited with the number of actual Hours Worked under a related plan for which contributions are transferred to this Trust. When this Trust transfers contributions to a related plan, the related plan may have different rules.

For example, the related plan may determine the number of hours to be credited under its plan based on the amount of money transferred to it and its contribution rate for the health and welfare coverage. For instance, if \$600 is transferred from this Trust to a related plan on behalf of a Carpenter and the contribution rate is \$6.00 under the related plan receiving the \$600 then

the Carpenter would be credited with 100 hours under that related plan (\$600 divided by \$6.00 = 100).

The Carpenter must file a written authorization form electing to have contributions transferred within **60 days** of the commencement of employment within another jurisdiction. Reciprocal agreements must also be in effect between this Trust and the other trusts. The transfer of hours is limited to Hours Worked up to one year prior to receipt of the transfer request. The transfer of hours will continue until the Carpenter has revoked the reciprocity request in writing and request is received by the home fund of the Carpenter.

If your eligibility is rejected because of insufficient Hours Worked and credited under the Southwest Carpenters Health and Welfare Trust, you should advise the Administrative Office if you worked in an area covered by another trust.

Contact the Administrative Office for more information about reciprocity.

Active Carpenters Who Become Disabled: Credit for Disability Hours for Disabilities Incurred on or after January 1, 2019

If disabled prior to January 1, 2019, contact the Administrative Office.

Effective for disabilities occurring on or after January 1, 2019, if an Active Carpenter becomes Disabled (defined below) in a Work Quarter, the Active Carpenter will be **credited** in that Work Quarter and the immediately following Work Quarter, with disability hours at the **rate of eight (8) hours each day** the Active Carpenter is Disabled (excluding Saturdays, Sundays and holidays).

No disability hours will be credited unless **all** of the following requirements are met:

- a. The total of disability hours credited and Hours Worked in a Work Quarter may not exceed the minimum Hours Worked to maintain eligibility.
- b. The maximum number of disability hours that can be credited during a Work Quarter is 360, less the number of hours actually worked during that quarter.
- c. **Disability hours credit can be given for a maximum of two consecutive Work Quarters.**
- d. **Disability hours will be credited once all the following requirements are met:**
 1. The Disabled status must be certified in writing by a Physician who is a medical doctor (an Active Carpenter is deemed to be “**Disabled**” when the Carpenter is **unable to perform the regular and customary duties of the Carpenter’s occupation because of an illness or injury**); and
 2. Such written certification of the Disabled status must be submitted to the Administrative Office within 120 days following the date the Active Carpenter became Disabled (as determined by the treating Physician); and
 3. The Active Carpenter must have been credited with Hours Worked for reasons other than having been Disabled or on a qualified family or medical leave within the 90-day period ending on the date the Active Carpenter became Disabled; and
 4. The Active Carpenter must have been an Eligible Individual on a non-self-pay basis during both of the two (2) consecutive Eligibility Quarters that ended immediately prior to the commencement of the Eligibility Quarter in which the Active Carpenter became Disabled; and
 5. the Active Carpenter must not be receiving a Pension Benefit from the Southwest Carpenters Pension Trust.

You must act promptly to receive this extension of eligibility for you and your family following an injury or sickness that prevents you from working sufficient hours to maintain your eligibility under the Plan.

Delays in filing a disability hours claim form (that is supported by a medical certification from a doctor) **may result in a denial of your application.**

The Active Carpenter is to **submit a request for crediting of disability hours** along with the **Physician's written certification of the disability** to the Administrative Office within the time limits specified above. The Administrative Office will make a determination on the request and notify the Active Carpenter in writing whether the request for crediting of disability hours is approved or denied (a denial is called an Adverse Benefit Determination). The Active Carpenter can appeal an Adverse Benefit Determination by following the Plan's disability claim appeal process, outlined in Chapter 15.

Self-Payment (Hours Buy Back) Provision

Effective July 1, 2018, a self-payment (hours buy back) provision is added as a way to help qualified employees maintain their eligibility for benefits. If an Active Carpenter would lose eligibility because their combined Hours Worked and reserve hours are less than the minimum needed to maintain eligibility for any Eligibility Quarter, the Active Carpenter will be allowed to pay the amount of contributions needed to meet the minimum hours needed to maintain eligibility for one Eligibility Quarter.

This means that the self-payment (hours buy back) provision will allow an employee to make a payment to the Fund for the difference in their hour bank balance and one quarter of eligibility. The self-payment will then allow the employee to maintain eligibility for this additional quarter (when that employee would have otherwise lost eligibility). These rules apply to the self-payment provision:

- a. This self-payment (hours buy back) provision does not apply to employees who have not established initial eligibility under the Fund.
- b. The self-payment (hours buy back) provision is **only permitted** if the employee is short **up to 60 work or bank hours**. Employees who are short **more than 60 work or bank hours** are not eligible for this self-payment provision.
- c. **The self-payment provision is only offered once each Calendar Year upon initial loss of coverage.**

For example: Your work hours combined with your reserve bank equal 340 hours (meaning you are short 20 work hours to retain eligibility for benefits for the next Eligibility Quarter). You can make a self-payment for the remaining 20 hours (360 needed minus 340 balance in your bank). Your self-payment is based on the hours needed to achieve eligibility multiplied by the current hourly rate specified in the Master Labor Agreement. In this case, your self-payment would be 20 hours multiplied by \$7.50 or \$150 to maintain your eligibility for the quarter. (Note that this self-payment premium is substantially less expensive than a normal monthly COBRA premium payment.) If you have not earned active eligibility following that quarter, you will be allowed to continue coverage under the COBRA continuation provisions.

Eligibility for Special Class Employees

Special Class Employees consist of Superintendents, trustees, certain employees of the Union, non-bargaining unit employees of a Contributing Employer, employees of Carpenters Southwest Administrative Corporation (CSAC) and employees of related service providers, where the employers of such persons have agreed to adopt and subscribe to the Plan in accordance with the Trust's procedures and paid contributions based upon assumed full-time work.

Special Class Employees are eligible for Plan benefits as noted below:

a. C4A Program.

Certain officers of Contributing Employers performing Carpenter work as described in an applicable Collective Bargaining Agreement, certain Carpenter craft Superintendents, and certain project managers and estimators may become Eligible Individuals based upon contributions for 173 Hours Worked per month. Such participation will be in accordance with Rules and Regulations adopted by the Board or its Delegate from time-to-time with respect to the “C4A Program.”

b. Trustees.

A Contributing Employer who employs a Trustee may elect Plan coverage for such Trustee to take effect as of the first day of any calendar month, by making advance application to the Administrative Office in the manner stipulated by it.

c. Certain Employees of the Union.

The Union (or unit thereof) may elect Plan coverage for its employees subject to the requirement that the Union will, by electing such coverage, be obligated to contribute to the Trust for all such employees for any calendar month in which it contributes for any such employee.

d. Non-bargaining Unit Employees of a Contributing Employer.

A Contributing Employer may elect Plan coverage for its employees who are not members of a collective bargaining unit by execution of an agreement substantially in the form of Appendix I to this Plan, and the acceptance thereof by the Board or its Delegate.

e. Employees of CSAC.

All employees of CSAC may become Eligible Individuals upon enrollment and payment of contributions pursuant to any applicable participation agreement or Collective Bargaining Agreement which has been accepted by the Board or its Delegate.

f. Related Service Providers.

A licensed professional firm that commenced contributions to the Trust prior to December 16, 1987 may continue coverage of its employees under the Plan. All employees of the firm, other than members of a collective bargaining unit, will be provided coverage. Should the firm elect not to continue coverage for any employee, coverage will cease for all. If such a firm discontinues coverage for all such employees, it may again elect coverage for all such employees commencing on the first day of any subsequent calendar month.

Such a firm which has employees covered by a non-Carpenter bargaining unit, such as with an office workers union, may provide coverage under the Plan, effective with such Collective Bargaining Agreement, to members of such unit, with the Administrative Office’s consent, on the terms and conditions applicable to non-Carpenter bargaining unit employees.

Such a firm having a new hire subject to the 173 hour per month contribution requirement may, with the Administrative Office’s consent, provide for Eligible Individual status to commence on the date of such hire, the first day of the first month following such hire, or the first day of the subsequent month, provided (i) a contribution for 173 hours is paid for each month or portion of month for which Eligible Individual status exists for such new hire and (ii) no Reserve Account will be provided for such new hire.

Such a firm may elect prospectively, with the Administrative Office’s consent, to have all of its bargaining unit and non-bargaining unit employees covered under either the 173 hour per month

contribution requirement applicable to Non-Bargaining Unit Employees of a Contributing Employer or the requirement applicable to Special Class Employees, (but not both), with eligibility for all new hires as described in the preceding sentence provided that for such firm's employees all existing Reserve Accounts will be cancelled effective with such uniform coverage requirement, and no such Reserve Accounts will thereafter accrue, and, if the 173 hour requirement is selected, a premium is paid as provided in the preceding sentence for each new hire.

Commencement and Continuation of Eligible Individual Status for Special Class Employees

a. In General

A Special Class Employee will become an Eligible Individual on the first day of the first calendar month following the hire date and will continue to be an Eligible Individual during such month, and during each subsequent calendar month for which such conditions continue to be satisfied, subject to earlier termination of Eligible Individual status prior to the end of such a calendar month.

Where the rule for an employer group of Special Class Employees generally requires coverage of all such eligible employees, the Administrative Office may permit exclusions of employees who provide documentation of group health coverage made available to them elsewhere, such as through a Spouse's employment. Upon presentation of documentation of the loss of such other coverage, such an excluded employee may specially enroll under the rules of the Plan.

b. CSAC Employees and Non-Bargaining Unit Employees.

- (i) Each employee of CSAC who is not a member of a collective bargaining unit will become an Eligible Individual on the first day of such employee's employment with CSAC where such employment is to be at least 30 hours per week;
- (ii) Each employee of CSAC who is a member of a collective bargaining unit will become an Eligible Individual on the first day of the first calendar month following completion of 30 consecutive days of employment of at least 30 hours per week.

Coverage under the foregoing rules will all be subject to limitations on the commencement and continuation of Eligible Individual status, with respect to Special Class Employees eligible which are contained in the applicable subscription or participation agreement.

A Special Class Employee will be an Eligible Individual during a calendar month only if at such point prior to the first day of such month, or within such grace period thereafter, as the Administrative Office requires

- (i) the Administrative Office's applicable procedures have been satisfied, and its enrollment or other documentation completed to its satisfaction, and delivered to it, and
- (ii) the contribution required of the employer is received by the Trust.

The required monthly contribution in the case of Special Class Employees will be the monthly premium set forth in the Employer Participation Agreement for Non-Bargaining employees as approved by the Board of Trustees. The required monthly contribution for each other Special Class Employee to the Trust will be the hourly rate specified in the Master Labor Agreement multiplied by:

- (i) 173 or
- (ii) in the case of Union or CSAC employees, regular non-overtime hours scheduled to be worked in the month prior to the month for which the employee will be an Eligible Individual.

For the purpose of developing a Reserve Account which will allow their continuance of their Eligible Individual Status, should they cease to be employed as Special Class Employees, such Special Class Employees shall be credited with hours that are in excess of the number of hours described in the prior paragraph.

Employees of the Southwest Carpenters Training Fund

Employees of the Southwest Carpenters Training Fund will become Eligible Individuals as consistent with the foregoing rules applicable to non-collectively bargained CSAC employees. By enrollment of its employees, Southwest Carpenters Training Fund agrees to make contributions to the Trust consistent with the foregoing rules applicable to non-collectively bargained CSAC employees.

If you are a Special Class Employee, refer to your eligibility requirements of the applicable Employer Participation Agreement for Non-bargaining Employees, if different than described in the Overview of Eligibility appearing earlier in this Chapter.

Eligibility for Eligible Dependents

In order to establish coverage for Dependents, you must provide certain documents to the Administrative Office, as noted in the “Enrollment” section later in this chapter.

When the Employee is enrolled, the following eligible Dependents may be enrolled for health coverage under the Plan:

- a. Your **lawful Spouse**. If you are legally separated from your Spouse, that Spouse is not eligible. Also, an ex-Spouse (divorced Spouse) is not eligible even if an employee is required by a divorce decree, court order, or other legal action to continue to provide coverage for the ex-Spouse.
- b. Your **children (married or unmarried) through the end of the month they turn age 26**. These children can be your natural children, stepchildren, children for whom you or your lawful Spouse are court appointed legal guardian, or children you’ve adopted or who have been placed with you for adoption prior to age 18.
- c. **Adult Disabled Child:** Your unmarried child who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than twelve (12) months, can continue eligibility as a Dependent after age 26 while such disabling condition exists, provided:
 - 1) such child was an eligible Dependent under the Plan at the time coverage otherwise would terminate due to age and
 - 2) you provide more than one-half of such unmarried child’s support for the Calendar Year and the child is eligible for tax-free health coverage as a “qualifying child” or “qualifying relative” under the applicable requirements of the Internal Revenue Code section 152 I or 152 (d).Appropriate documentation must be provided to the Administrative Office within 60 days of the Dependent’s termination date and periodically as requested by the Administrative Office.
- d. A child covered by a **Qualified Medical Child Support Order (QMCSO)**. For information on the Plan’s procedures regarding QMCSOs, contact the Administrative Office.

The following Dependents may be covered for life insurance and any other non-health benefits that may be provided by the Plan:

- a. Your **lawful Spouse**. If you are legally separated from your Spouse, that Spouse is not eligible. An ex-Spouse is not eligible even if an employee is required by a divorce decree, court order, or other legal action to continue to provide coverage for the ex-Spouse.

- b. Your **unmarried children through the end of the month they turn age 19** if you provide more than one-half of their support.
- c. Your **unmarried children through the end of the month they turn age 23** if they are unmarried, supported by the employee, not employed on a full-time basis and a full time students in an accredited institution of learning (under that institution’s standards for full time students) if you provide more than one-half of their support.

For life insurance benefits, a person who, while enrolled as a full-time student:

- a. leaves school because of a Medically Necessary leave of absence; and
- b. whose absence is certified in writing as necessary by a Physician;

will be considered to have the status of a full-time student for the lesser of: (i) 12 months or (ii) the length of the approved leave of absence.

For the purposes of determining which Dependents may become covered for life insurance, the term does not include any person who:

- a. is on active duty in the military of any country or international authority; however, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard; or
- b. is insured under the Life Insurance Group Policy as an Employee.

For life insurance, you must also provide for your children, a copy of your most recent federal income tax return showing that you claim the children as your Dependents.

For purposes of life insurance, your Domestic Partner may be covered as a Dependent on the life insurance policy. **“Domestic Partner”** means each of two people, one of whom is an Employee of the Policyholder or Participating Employer, who:

- a. have registered as each other’s domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available; or
- b. are of the same or opposite sex and have a mutually Dependent relationship so that each has an insurable interest in the life of the other. Each person must be:
 - 1. 18 years of age or older;
 - 2. unmarried;
 - 3. the sole domestic partner of the other;
 - 4. sharing a primary residence with the other; and
 - 5. not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.

A Domestic Partner declaration attesting to the relationship between the Employee and the Employee’s domestic partner must be completed and signed by the Employee. The declaration must establish that each person has either a substantial interest in the other engendered by love and affection; or a lawful and substantial economic interest in the continued life, health or bodily safety of each other, as distinguished from an interest which would arise only by, or would be enhanced in value by, the death, disablement or injury of the other person.

Verification of a Domestic Partner must be provided to the Life Insurance carrier.

IMPORTANT NOTE: Any Spouse or child that is an Eligible Individual under the Plan as an employee (Active Carpenter or Special Class Employee) cannot also be eligible as a Dependent. Nor can children be covered as Dependents of more than one employee (Active Carpenter or Special Class Employee) under the Plan.

See the definition of “Dependent” in the Glossary Chapter at the end this booklet for more detailed information on the requirements for Dependent status.

Eligibility Dates for Dependents

Your Dependents will become eligible upon their enrollment on the later of:

- a. the date you become an Eligible Individual, or
- b. the date you acquire the Dependent if you are then eligible; however, a Dependent of a CSAC employee who is a member of a collective bargaining unit will not become eligible before the first day of the first month following the employee’s acquisition of the Dependent, unless acquisition is by birth, adoption or placement for adoption.
- c. actively at work non-bargaining employees residing in the U.S. and working at least 30 hours per week will be eligible for Dependent life insurance on the later of the first day of the month coincident with or next following the date you complete the waiting period of 30 days.

Properly completed enrollment forms and required documents must be submitted to the Administrative Office timely in order for coverage to become effective by the first day of the month in which the Administrative Office receives your completed forms and documents.

Notwithstanding the preceding general rule, Dependents of Special Class Employees will become eligible in accordance with the applicable provisions of the agreement between the Contributing Employer and the Trust.

A Dependent’s eligibility will continue during any period that the Active Carpenter or Special Class Employee from whom the Dependent’s status as a Dependent is derived is an Eligible Individual, unless it is terminated earlier for one of the reasons under “When Eligibility Terminates” later in this Chapter.

Important Notice about Changes in Your Family

If there is a change in your family status (for instance, if you get married or divorced, or have a child), you must complete a family status form and mail it along with any required documentation **to the Administrative Office within 31 days of the event**. Otherwise, coverage is delayed or, in the case of divorce, you will be responsible for any costs the Trust incurs on behalf of ineligible Dependents including but not limited to, your former Spouse and any stepchildren after divorce from the parent of the stepchildren.

Family status forms are available from the Administrative Office and the Trust’s website www.carpenterssw.org.

Plan Options And Enrollment

Choice of Coverage.

Various medical care options are available under the Plan. The options available to you will depend on where you live and how long you have been eligible under the Plan.

Employees, other than Dependents, who first acquire eligibility under the Plan will be given an opportunity to select health coverage among the options then available. If a Dependent is properly enrolled, that Eligible Dependent will receive the same health care coverage that is elected by the Eligible Employee (from whom the Dependent’s status as a Dependent is derived), except as otherwise required by applicable law.

- If the Eligible Employee does not reside in any HMO service area, then only the Anthem Medical PPO Plan will be provided.
- See the Dental chapter for information on which Dental plan options are available based on where the Eligible Employee resides.
- If the Administrative Office does not receive a “timely” and properly completed medical and/or dental enrollment form from an Eligible Employee, such Eligible Employee and their eligible Dependents will not have medical and/or dental coverage, as applicable, until the first day of the month following the date the Plan (the Administrative Office) receives the properly completed enrollment form(s).
- Submission of a properly completed enrollment form will be deemed timely if it is received by the Administrative Office **within 31 days** following the date an Employee’s status meets the eligibility provisions of the Plan.
- NOTE: Regardless of which medical care option you are enrolled in, you will be eligible to elect one of the Dental plan options.
- As long as you are enrolled in the Kaiser Deductible HMO Medical plan or Anthem Medical PPO Plan, you and your Dependents will automatically be covered under the Vision plan coverage and Life insurance, and the employee will be covered under the Life insurance and accidental death and dismemberment benefits. However, Life insurance, and accidental death and dismemberment benefits are not provided to COBRA beneficiaries, as discussed later in the COBRA section of this Chapter.

Medical Care Options

The medical care options are as follows:

- The **Anthem Medical PPO Plan** provides a PPO Network where in-network providers extend a discount on their services which reduces your Out-of-Pocket costs. If you are enrolled in the Anthem Medical PPO Plan, you and your eligible Dependents are covered for Hospital, medical, Behavioral Health and Prescription Drug services as described in Chapter 5.

The Anthem Medical PPO Plan is available in all geographical locations in the U.S.

An Active Carpenter or Special Class Employee is considered to be “newly eligible” if he/she has not previously been an Eligible Individual or has been ineligible for the Plan for two consecutive Eligibility Quarters and then regains eligibility.

- The **Kaiser Deductible HMO Medical Plan**, is a program of managed medical care provided through Kaiser Permanente, a health maintenance organization or “HMO.” If you are enrolled in the Kaiser Deductible HMO Medical Plan, you and your eligible Dependents are covered under Kaiser for Hospital, medical, behavioral health, and Prescription Drug services and supplies as described in Kaiser’s benefit booklet. Generally, Kaiser provides its HMO Medical Plan benefits through its own facilities. Kaiser is available in most areas of Southern California, some areas in Northern California, and in Colorado.

Dental Care Options

The dental care options are as follows:

- **UnitedHealthcare Dental Preferred Provider Organization (DPPO) Dental Plan:** This dental plan option is available if you live in any state in the US.
- **UnitedHealthcare Select Managed Care Direct Compensation (DC) Dental Plan:** This dental plan option is available if you live in California or Nevada.

- **UnitedHealthcare In-Network Only (INO) Dental Plan:** This dental plan option is available if you live in Colorado, Utah, Wyoming or most other states (but not California or Nevada).

Enrollment Opportunities

There are three enrollment opportunities for eligible employees and eligible Dependents: Initial Enrollment, Special Enrollment and Open Enrollment. These enrollment opportunities are outlined below.

Initial Enrollment

When to Make Your Coverage Selections

You are given the opportunity to make your selections among available medical and dental care options when you first become an Eligible Individual under the Plan. Your Dependents may only be enrolled under your selected coverage options. Once enrolled in the options you have selected, generally, **you may change your selection only during the Plan’s annual Open Enrollment period.**

Each year the Administrative Office will notify you of the Plan’s Open Enrollment period. However, you may also change your selection if you are enrolled in an HMO Medical Plan and/or an in-network only Dental plan and you move away from its network service area. You must notify the Administrative Office in writing of your change in address and request a change in your coverage.

In the event you are not eligible for Plan benefits during an annual Open Enrollment period, you may change your option selections as of the date you reestablish eligibility under the Plan, provided two consecutive Eligibility Quarters have not elapsed.

Individuals enrolled during a Special Enrollment period as described under HIPAA Special Enrollment later in this Chapter have the same opportunity to select Plan benefit options at the same costs and the same enrollment requirements as are available to similarly situated employees at initial enrollment.

As with all newly enrolled individuals, medical coverage selection is limited to the Plan’s HMO Medical Plan (available in some states), or the PPO option. Dependents can only be enrolled under the medical plan selected by the Active Carpenter or Special Class employee. The Plan’s medical options may not be available to individuals who owe money to the Plan.

How to Make Your Coverage Selections

Enrollment Forms

To select your coverage Options, complete and return the appropriate enrollment forms to the Administrative Office by the deadline given to you. **It is very important the Administrative Office have completed enrollment forms by the stated deadline; otherwise, you will not have ANY medical, Prescription Drug, dental, or vision benefits until enrollment forms are received.**

Remember, you can make option selections only during the enrollment periods noted in the preceding section.

Declining (Opt Out of) Coverage

Once you become covered under the Plan, benefits-eligible employees and their eligible Dependents will be offered the opportunity to decline (opt out of) benefits coverage.

To decline (opt out of) benefits, you must provide proof of enrollment in other group coverage that is considered to be minimum essential coverage (MEC) or COBRA coverage, as well as complete a form to decline benefits by contacting the Administrative Office. Other “group coverage” does not include coverage under Medicaid, Medicare, Tricare, Indian Health Services, or the Health Insurance Marketplace.

If at a later date you want the Fund’s coverage that you declined (opted out of), and you are then eligible for Fund-sponsored coverage, you may be able to take advantage of the Special Enrollment provisions (such as if you lose eligibility for that other coverage), or you can make an election for to enroll for the Fund’s benefits at the next Open Enrollment time.

There is no financial compensation for declining (opting out of) coverage.

Documentation for Dependents (Proof of Dependent Status)

Be sure to include with your enrollment forms, the documents necessary to establish eligibility for your Dependents. Those documents are:

- a. for your Spouse, a certified copy of your marriage certificate and a copy of your most recent federal income tax return showing that you filed a married joint return or married filed separately return. (Contact the Administrative Office for alternative documentation options.)
- b. for your natural children, a certified copy of their birth certificates.
- c. for your adopted children or children for whom you are legal guardian, a certified copy of the adoption papers or court order showing your legal responsibility for each child.
- d. for your stepchildren, a certified copy of their birth certificates (note: in order to enroll stepchildren, a certified copy of your marriage certificate is required)
- e. for your children between the ages of 19 and 23 and attending school full time (under that institution’s standards for full time students), a completed student certification form for each child (this form can be obtained from the Administrative Office).
- f. for children for whom you are legally responsible for providing health coverage, a copy of the Qualified Medical Child Support Order (QMCSO).
- g. for your children for Dependent life insurance purposes, a copy of your most recent federal income tax return showing that you claim the children as your Dependents. This is required for Dependent life insurance only. Contact the Administrative Office for alternative documentation options.

In order for your Dependents to become Eligible Individuals under the Plan, you **must** provide the documents listed above to the Administrative Office in a timely manner. **Failure to provide the required proof of Dependent documentation may affect your Dependent’s eligibility for benefits.**

A Dependent’s Social Security Number (SSN) will also be needed as explained below:

DEPENDENT SOCIAL SECURITY NUMBERS NEEDED

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

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

Failure to provide the SSN or failure to complete the CMS model form (form is available from the Administrative Office or <http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Downloads/New-Downloads/RevisedHICNSSNForm081809.pdf>) means that claims for Eligible Individuals may not be considered a payable claim for the affected individuals.

Qualified Medical Child Support Orders (QMCSO)

Procedure for Notification and Determination of Qualified Status: In the event that a Medical Child Support Order (National Medical Support Notice) is received by the Plan, the Administrative Office will promptly notify the affected Eligible Individuals (including the Alternate Recipient potentially affected or the Alternate Recipient's representative) of the receipt of such order and the Plan's procedures for determining the qualified status of such order under Section 609 of ERISA.

The Plan will then, within a reasonable period after receipt of such order, determine whether such order is a Qualified Medical Child Support Order in accordance with written procedures, and notify the affected Eligible Individual and each Alternate Recipient of its determination.

If an affected Eligible Individual is dissatisfied with the determination of the Administrative Office, that Individual may appeal the Administrative Office's decision by following the Plan's procedure for appealing denied claims.

Direct Reimbursement to Alternate Recipient: Notwithstanding any other provision of the Plan, any payment for benefits made by the Plan pursuant to a Qualified Medical Child Support Order in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian will be made to the Alternate Recipient or Alternate Recipient's custodial parent or legal guardian.

Definitions Related to QMCSOs:

- The term "**Alternate Recipient**" means any child of any Eligible Individual who is recognized under a Medical Child Support Order as having a right to enrollment under the Plan.
- The term "**Medical Child Support Order**" means any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction which either (a) provides for child support with respect to a child of an Eligible Individual who is not a Dependent or provides for health benefit coverage to such a child, is made pursuant to a State domestic relations law (including a community property law), and which relates to benefits under the Plan, or (b) enforces a law relating to medical child support, described in 42 U.S.C. Section 1396g-1, with respect to the Plan.

The term “**Qualified Medical Child Support Order**” means a Medical Child Support Order which creates or recognizes the existence of an Alternate Recipient’s right to, or assigns to an Alternate Recipient the right to, receive benefits for which an Eligible Individual is eligible under the terms of the Plan. A Qualified Medical Child Support Order must clearly specify:

- 1) the name and last known mailing address of the Eligible Individual and each Alternate Recipient;
- 2) a reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;
- 3) the period to which such order applies; and
- 4) each Plan to which the order applies.

A Qualified Medical Child Support Order may not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in 42 U.S.C. Section 1396g-1.

For information on the Plan’s procedures regarding QMCSOs, available at no cost, contact the Administrative Office.

HIPAA Special Enrollment

There are three HIPAA Special Enrollment opportunities permitting Eligible Individual to enroll in the Plan mid-year: a) upon gaining (acquiring) a new Dependent, b) loss of other coverage, and c) on account of Medicaid or a State Children’s Health Insurance Program (CHIP). These opportunities are explained below:

- a. If you acquire a new Dependent as a result of **marriage, birth, adoption** or placement of a child with you for adoption, you can request enrollment for your new Dependent retroactive to the date he/she attained Dependent status as long as you notify the Administrative Office in writing within **31 days** of the marriage, birth, adoption or placement for adoption. If not, they cannot be enrolled in Plan coverage until the next Open Enrollment period.

(Note: A child is “Placed for Adoption” with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.)

- b. If you decide not to enroll yourself or your Dependents because you and/or they have other health coverage, you may be eligible to request enrollment for yourself and/or your Dependents in Plan coverage before the next Open Enrollment Period if you and/or your Dependents **lose other health coverage** (for certain reasons). You must notify the Administrative Office and submit an enrollment application within **31 days** after the other coverage ends.
- c. If you or your Dependents **lose eligibility for Medicaid or Children’s Health Insurance Program (CHIP)**, or become eligible for a state subsidy (premium assistance program) for enrollment in the Plan under Medicaid or CHIP, you must request enrollment for yourself/your Dependents in Plan coverage within **60 days** after coverage in Medicaid/CHIP ends or the date you/they became eligible for the subsidy. If you properly enroll yourself and/or your Dependents within these periods, coverage will be retroactive to the date the prior coverage ended.

To request enrollment under the HIPAA Special Enrollment provision, contact the Administrative Office.

Individuals enrolled during a special enrollment period have the same opportunity to select Plan benefit options at the same costs and the same enrollment requirements as are available to similarly

situated employees at initial enrollment.

Open Enrollment

Open Enrollment is the period of time each year to be designated by the Administrative Office during which benefits-eligible employees, and COBRA qualified beneficiaries may make the elections specified below. Enrollment forms and information may be obtained from the Administrative Office.

Individuals enrolled during Open Enrollment should follow the procedures explained at the time of Open Enrollment.

Elections Available During Open Enrollment:

During the Open Enrollment period, you may elect, for yourself and your Eligible Dependents who are eligible for coverage, to

- a. **enroll** in one of the medical, dental and vision plans offered, or
- b. **add or drop** Eligible Dependents to the medical, dental, or vision coverage, or
- c. **change** medical or dental plans (when a change is permissible) or
- d. make **changes to beneficiary information** for your life insurance.

Restrictions on Elections During Open Enrollment:

No Dependent may be covered unless you are covered (unless the Dependent is a COBRA Qualified Beneficiary).

You and all your covered Eligible Dependents must be enrolled for the same medical dental, and/or vision coverages.

All relevant parts of the enrollment form must be completed and the form must be submitted before the end of the Open Enrollment period to the Administrative Office along with proof of Dependent status (as requested) if adding a new Dependent for coverage.

Frequently Asked Questions

Q. What should I do if my family situation changes after I submit my enrollment forms?

A. Please be sure to complete a family status change form and send it to the Administrative Office immediately when any change occurs in your family status (for example, marriage, birth of a child, death, divorce, legal separation or annulment). Family status forms are available from the Administrative Office.

You should also notify the Administrative Office in writing if you change your home address. **Failure to give the Administrative Office a timely notice of the above noted events may:**

- a. cause you, your Spouse and/or Dependent Child(ren) to lose the right to obtain COBRA Continuation Coverage,
- b. cause coverage of a Dependent Child to end when it otherwise might continue because of a disability,
- c. cause claims to not be considered for payment until eligibility issues have been resolved,
- d. result in your liability to repay the Plan if any benefits are paid to an ineligible person. The Plan also has the right to offset the amounts paid against the participant's future health benefits.

Moving Outside The Network Service Area

If you are enrolled for coverage in one of the Plan's Health Maintenance Organizations (HMO) or Dental in-network only plan, that provides benefits for covered healthcare services if you reside within a specified geographic network service area; **and** you move your residence to a place outside that service area; then you may request to change Plan options mid-year. To make such a change, contact the Administrative Office **within 31 days** of the date you changed your residence.

Beneficiary Card For Life Insurance

Every employee who is working for a Contributing Employer should complete a life insurance beneficiary card naming a beneficiary. Beneficiary cards are available at the Administrative Office and Local Union offices. The beneficiary card is the means by which an employee may designate the beneficiary for their life insurance and accidental death benefits. The designated beneficiary can receive the life insurance policy's death benefit upon the death of the owner of the policy.

In the absence of a beneficiary designation, there may be delays in the payment of these benefits, and they will be paid as required by the life insurance contract, which may differ from what you would have provided in a beneficiary card.

If you **want to change your beneficiary**, get another card from your Local Union or the Administrative Office, fill it out completely and send it to the Administrative Office. A new beneficiary card is not necessary for a change in address or local number, but you also should advise the Administrative Office of any such changes in writing.

A completed life insurance beneficiary card is the only document that the Trust will accept regarding your choice of beneficiary. For example, if you execute a will or obtain a dissolution of marriage,

those documents or court orders will not be effective to change your designated beneficiary for your life insurance benefits. You must instead complete and return a new beneficiary card to the Administrative Office.

If You Also Have Coverage Elsewhere (Coordination Of Benefits)

If you or your Dependents have coverage under this Plan and **also have** health care coverage elsewhere, you should be aware that coverage provided under the benefits described in this booklet will be coordinated with that other coverage – you cannot receive duplicate benefit payments or use dual coverage to get reimbursed for more than 100% of your expenses.

See Chapter 9 for more information on Coordination of Benefits (COB).

In addition, no individual may be covered under any of the Plan’s benefits as both an employee and as a Dependent, or as a Dependent of more than one employee.

Coverage During A Family Or Medical Leave (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) entitles certain eligible employees to take up to **12 weeks (26 weeks in certain situations)** of unpaid, job-protected leave each year for specified family and medical reasons. A covered employer is required to maintain group health coverage for an employee on FMLA leave whenever such coverage was provided to the employee immediately before the leave. To be eligible for FMLA benefits, an employee must:

- work for a covered employer who employs 50 or more employees,
- have worked for that covered employer for at least 12 months,
- have worked at least 1,250 hours for that covered employer over the previous 12 months, and
- work at a location where at least 50 employees are employed by that covered employer within 75 miles.

The service requirements must be met by your work for a single employer. If you worked for more than one employer, you **CANNOT** combine your work history under all the employers for whom you worked to meet the service requirements outlined above.

Please note that, for a leave of absence covered by FMLA, your Employer must properly grant the leave and make the required notification and any required payment to the Administrative Office. You should contact your Employer to confirm that you are eligible for a leave of absence.

Any banked hours in your reserve account are applied to cover the contributions owed for a period of FMLA leave. After the banked hours in your reserve account are exhausted, the contribution due from your Employer is the amount required by the Collective Bargaining Agreement for the period of the leave. For more information on the FMLA, contact your employer.

Coverage During Military Leave (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”) requires that the Plan provide the right to elect continued health coverage for up to **24 months** to you if you are absent from employment due to military service, including Reserve and National Guard Duty under federal authority, as described below.

Coverage Under USERRA

If you are absent from employment because of service in the Uniformed Services, you can elect to continue coverage for yourself and/or your eligible Dependents under the provisions of USERRA. The right to elect USERRA coverage does not apply to Dependents that enter military service. Further, USERRA rights do not apply to service in a state national guard under authority of state law.

The period of coverage available under USERRA begins on the date on which your absence begins and ends on the earlier of:

- the end of the **24-month period** beginning on the date on which the absence begins; or
- the day after the date on which you are required to, but fail to, apply under USERRA for or return to a position of employment for which contributions must be made to the Trust.

This right to temporarily continue coverage from the Plan does not include the right to receive any life insurance, accidental death and dismemberment, or long term disability benefits or other similar non-health benefits provided under the Plan. In addition to the right to continued coverage under USERRA, you and your Dependents also may have rights to elect continuation coverage under COBRA, if they experience a Qualifying Event.

Notice and Election of USERRA Coverage

If you want to elect USERRA coverage, you must notify the Administrative Office of your absence from employment due to military service, unless giving notice is precluded by military necessity or unless, under all the relevant circumstances, notice is impossible or unreasonable.

In addition, your election to receive USERRA coverage must be received within 60 days of the last day of Covered Employment; otherwise, you lose your right to continue your coverage under USERRA.

Paying for USERRA Coverage

You may be required to pay all or a portion of the cost of coverage. If the period of military service is less than 31 days, coverage under the Plan will continue as if you were still working in Covered Employment. If the military service extends more than 31 days, you must pay 102% of the cost of the coverage unless the Employer pays for the coverage under its leave policy. The cost will be determined in the same manner as the cost for COBRA continuation coverage. You should contact the Administrative Office for the current cost.

USERRA coverage requires timely monthly payments

The payment due date is the first day of the month in which USERRA coverage begins. For example, payments for the month of November must be paid on or before November 1st. The payment due for the initial period of USERRA coverage must include payment for the period of time dating back to the date that coverage would have terminated if you had not elected USERRA coverage. There is an initial grace period of 45 days to pay the first premium due, starting with the date USERRA coverage was elected. After that, there is a grace period of 30 days to pay any subsequent amounts due.

If you timely elect and pay for USERRA coverage, coverage will be provided retroactive to the date

of your departure for military service. If payment is not received by the end of the applicable grace period, USERRA coverage will terminate as of the end of the last period for which payment was received.

If you fail to pay the full payment by each due date (or within the 30-day grace period), you will lose all USERRA coverage and such continuation coverage cannot be reinstated.

Once a timely election of USERRA coverage is made, it is your responsibility to make timely payments. The Administrative Office will not send notice that a payment is due or that it is late, or that USERRA coverage is about to be terminated due to the untimely payment of a required payment.

When you return to Covered Employment after receiving an honorable discharge within the time periods required by law, you will be eligible to continue your coverage from the Plan. However, if there is no balance remaining in your reserve account at that time, you must self-pay your premiums in order to continue your coverage.

When Eligibility Terminates

Termination of Eligibility under the Plan

An Employee will cease to be an Eligible Individual effective:

- a. upon the effective date of an amendment to the Plan which excludes such Employee from coverage under the Plan,
- b. upon failure to pay any required self-payments and/or COBRA premiums,
- c. the date the Employee voluntarily declines enrollment in the Plan,
- d. the date of the complete termination of the Plan,
- e. and as follows:

Active Carpenters: An Active Carpenter's Plan eligibility, and therefore the Carpenter's status as an Eligible Individual, will **terminate on the last day of an Eligibility Quarter if the Hours Worked** for Contributing Employers during the most recent Work Quarter ending prior to the Eligibility Quarter, plus the hours in the Carpenter's reserve account, **do not total at least 360 hours** (or, if the Carpenter is still under an alternate eligibility rule as described under "Alternate Rules for Active Carpenters" earlier in this Chapter, the last day of the month if the Hours Worked during that month do not total at least the minimum hours set forth in the Collective Bargaining Agreement).

In such a case, legislation known as COBRA gives the Active Carpenter and his Dependents the option of temporarily continuing health care coverage at group rates at their own expense, provided coverage was established for a medical option based on enrollment information received by the Administrative Office prior to the termination date. See "COBRA Continuation Coverage" later in this Chapter for more information.

Special Class Employees: A Special Class Employee's Plan eligibility, and therefore the Employee's status as an Eligible Individual, will **terminate on the last day of the calendar month** in which the **employee ceases to be a member of an eligible group of Special Class Employees**.

Depending on the circumstances, the Employee and their Dependents may have the option of temporarily continuing health care coverage under COBRA at their own expense, provided coverage was established for a medical option under the Plan based on enrollment information received by the

Administrative Office prior to the termination date. See “COBRA Continuation Coverage” later in this Chapter for more information.

Dependent(s)

A Dependent will cease to be an Eligible Individual, on the earliest of:

- a. the date the Employee coverage ends (see below for the exception for continued eligibility for a surviving Dependent)
- b. the last day of the month in which the child reaches age 26 (age 23 for Dependent life insurance) and no longer meets the definition of a Dependent (unless the child is eligible to continue as an adult disabled child – For more information on adult disabled child, see the subsection titled “Eligibility for Eligible Dependents” earlier in this Chapter and the definition of “Dependent” in the Glossary Chapter.),
- c. the date the Spouse of the Active Carpenter or Special Class Employee ceases to be an Eligible Spouse under the Plan,
- d. the last day of the month in which the Dependent’s enrollment in this Plan is voluntarily declined,
- e. upon the effective date of an amendment to the Plan which excludes such Dependent from coverage under the Plan,
- f. upon failure to pay any required self-payments and/or COBRA premiums,
- g. the date of the complete termination of the Plan.

Depending on the circumstances, the employee and their Dependents may have the option of temporarily continuing health care coverage under COBRA at their own expense, provided coverage was established for a medical option under the Plan based on enrollment information received by the Administrative Office prior to the termination date. See “COBRA Continuation Coverage” later in this Chapter for more information.

Surviving Dependent(s)

In the event of an Active Carpenter’s death; the Active Carpenter’s surviving Dependent’s eligibility will continue for the period that such Active Carpenter would have remained eligible based upon the Active Carpenter’s work hours accumulated at their death; thereafter, the surviving Dependent may be offered temporary COBRA coverage (see also the subsection titled “Special Surviving Dependents Provision” later in the COBRA section in this Chapter).

A surviving Dependent will lose eligibility on the earliest of:

- a. the end of the month in which the surviving Dependent child no longer meets the definition of a Dependent child as defined in the Glossary Chapter in this document;
- b. the date the surviving Spouse remarries;
- c. upon the effective date of an amendment to the Plan which excludes a surviving Spouse or surviving Dependent Child from coverage under the Plan,
- d. upon failure to pay any required self-payments and/or COBRA premiums,
- e. the date of the complete termination of the Plan.

Legislation known as COBRA gives the surviving Dependent the option of temporarily continuing health care coverage at their own expense. Under certain circumstances, the cost of COBRA coverage for surviving Dependents may be subsidized by the Plan. For more information, see the section on “COBRA Continuation Coverage” later in this Chapter.

Options When Coverage Ends Under This Plan

When coverage under this Plan terminates you may have the option to:

- a. buy temporary continuation of this group health plan coverage by electing COBRA; or
- b. for insured health plan options, convert your group health insurance coverage to an individual insurance policy (when permitted by the insurance company); or
- c. look into your options to buy an individual insurance policy for health care coverage from the **Health Insurance Marketplace**.

Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov. In addition, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a Spouse's plan), if you request enrollment in that other plan within 30 days of losing coverage under this Plan.

When The Plan Can End Your Coverage For Cause (Rescission)

In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage (a rescission) except when employer contributions and self-payments are not timely paid (in full), or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan, as discussed below:

- a. The Plan Administrator or its Delegate may end your coverage (retroactively to the date that you or your covered Dependent performed or permitted the acts described below) and/or the coverage of any of your covered Dependents for cause 30 days after it gives you written notice of its finding that you or your covered Dependent:
 1. **engages in an act, practice or omission that constitutes fraud or an intentional misrepresentation of a fact** in any enrollment, claim or other form in order to obtain coverage, services or benefits under the Plan. Keeping an ineligible Dependent enrolled under the Plan (for example, an ex-Spouse, legally separated Spouse, over-age or ineligible Dependent child, etc.) is considered fraud; or
 2. **allowed anyone else to use the identification (ID) card** that entitles you or your covered Dependent to coverage, services or benefits under the Plan; or
 3. **altered any prescription** furnished by a Physician or other Health Care Practitioner.

If your coverage is terminated for any of the above reasons, it will be terminated retroactively (a rescission) to the date that you or your covered Dependent performed or permitted the acts described above.

For example, keeping an ineligible Dependent enrolled under the Plan (for example, an ex-Spouse, legally separated Spouse, over age or ineligible Dependent child, etc.) is considered fraud.

You must immediately notify the Administrative Office, in writing, of any change in the eligibility status for any Dependent enrolled for coverage under the Plan, such as divorce or other event resulting in a loss of eligibility.

Failure to notify the Plan of such a change in status will be deemed an act of omission constituting fraud or an intentional misrepresentation of a fact by the Participant and ineligible Dependent. Other situations of fraud or intentional misrepresentation of fact can

include failure to submit the required proof of Dependent status documentation or the documentation submitted does not confirm the Dependent is eligible as a Dependent for coverage under this Plan.

- b. The Plan Administrator or its Delegate may end your coverage and/or the coverage of any of your covered Dependents for cause 30 days after it gives you written notice of its finding that you or your covered Dependent(s) engaged in **conduct that was abusive, obstructive, or otherwise detrimental to a Physician or Health Care Practitioner**. If your coverage is terminated for this reason, it will be terminated on a going forward (prospective) basis.
- c. The Plan Administrator or its Delegate may end your coverage and/or the coverage of any of your covered Dependents for cause 15 days after it gives you written notice of its finding that the participating employer failed to make contributions for coverage or there is failure to make required self-payments for coverage. In this instance, your coverage will be terminated retroactively to the date of the delinquent premium payment (employer contribution or self-payment). In addition, your coverage may be suspended during the 15-day notice period.

Frequently Asked Questions

Q. Can I continue to cover my Spouse after a divorce?

A. No.

In the event of divorce or annulment, a Spouse ceases to be eligible as of the date of the final decree. Your former Spouse may, however, be entitled to temporary continuation coverage if the Administrative Office is notified of the divorce within 60 days of the date of that divorce. Refer to “COBRA Continuation Coverage” later in this Chapter.

To avoid payment of premiums or payment on claims of your ineligible former Spouse, **which you would have to refund to the Trust**, you must notify the Administrative Office in writing of the dissolution or annulment of the marriage as soon as it occurs. A copy of the final decree will be required.

COBRA Continuation Coverage

This section generally explains how you and your family may temporarily continue health coverage under the Plan after coverage otherwise would end because of a “Qualifying Event.” Under the Consolidated Omnibus Budget Reconciliation Act of 1985, a federal law more commonly known as “COBRA,” continuation coverage must be offered to each person who is a “Qualified Beneficiary.”

A **Qualified Beneficiary** is an employee, Spouse or Dependent child who will lose coverage under the Plan because of a “Qualifying Event.”

- A child who becomes a Dependent Child by birth, adoption or placement for adoption with the covered Qualified Beneficiary during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.
- A child of the covered employee who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO), during the employee’s period of employment, is entitled to the same rights under COBRA as an eligible Dependent child.
- A person who becomes the new Spouse of an existing COBRA participant during a period of COBRA Continuation Coverage may be added to the COBRA coverage of the existing COBRA participant but is not a “Qualified Beneficiary.” This means that if the existing COBRA

participant dies or divorces before the expiration of the maximum COBRA coverage period, the new Spouse is not entitled to elect COBRA.

A **Qualifying Event** triggers the opportunity to elect COBRA when the covered individual **loses** health care coverage under this Plan. If a covered individual has a Qualifying Event but, as a result, does not lose their health care coverage under this Plan, (e.g. employee continues working even though entitled to Medicare) then COBRA is not available.

Qualified Beneficiaries who elect COBRA continuation coverage must pay premiums on a monthly basis. Notice of the amount of the premium is included in the COBRA election notice sent to a Qualified Beneficiary after a Qualifying Event.

This Plan provides no greater COBRA rights than what is required by law and nothing in this Chapter is intended to expand a person's COBRA rights.

Other Health Coverage Alternatives to COBRA

Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the Health Insurance Marketplace (the Marketplace helps people without health coverage find and enroll in a health plan).

- For California residents: See your state Health Insurance Marketplace: www.coveredca.com or the federal Health Insurance Marketplace at www.healthcare.gov.
- For non-California residents: See your state Health Insurance Marketplace or the federal Health Insurance Marketplace at www.healthcare.gov.

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

COBRA Eligibility (COBRA – Qualifying Events)

For Employees

If you are an employee, COBRA continuation coverage is available to you if coverage otherwise would end because either one of the following Qualifying Events happens:

1. Your hours of covered work are reduced so that you are no longer eligible to participate in the Plan, or
2. Your employment ends for any reason other than gross misconduct.

For a Spouse

If you are the Spouse of an employee, COBRA continuation coverage is available to you if coverage otherwise would end because any one of the following Qualifying Events happens:

1. Your Spouse dies;
2. Your Spouse's hours of employment are reduced;
3. Your Spouse's employment ends for any reason other than gross misconduct; or
4. You become divorced or legally separated from your Spouse.

For Dependent Children

COBRA continuation coverage is available to your Dependent children if coverage otherwise would end because any one of the following Qualifying Events happens:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than gross misconduct;
4. The parents become divorced or legally separated; or
5. The child stops being eligible for coverage under the Plan as a "Dependent child."

Maximum Period of COBRA Continuation Coverage

The maximum period of COBRA Continuation Coverage is generally either **18 months** or **36 months**, depending on which Qualifying Event occurred, measured from the date eligibility otherwise would terminate under this Plan. (See the Maximum Duration chart below.) The 18-month period of COBRA Continuation Coverage may be extended for up to 11 months (making a total of **29 months**) under certain circumstances (described in another section of this Chapter on extending COBRA in cases of disability).

The maximum period of COBRA coverage may be cut short for the reasons described in the section on "Termination of COBRA Continuation Coverage" that appears later in this Chapter.

MAXIMUM DURATION OF COBRA CONTINUATION COVERAGE FOR DIFFERENT QUALIFYING EVENTS		
Qualifying Event	Who May Continue Coverage	Maximum Period of COBRA Continuation Coverage (measured from the date eligibility would otherwise terminate)
You (the Active Carpenter or Special Class Employee) lose eligibility due to: <ul style="list-style-type: none"> • a reduction in your hours of covered work, or • termination of your hours of covered work, including retirement. 	You, your Spouse, and/or your Dependent children covered under the Plan.	18 months*
You (the Active Carpenter or Special Class Employee) die	Your Spouse and/or your Dependent children covered under the Plan	36 months
You (the Active Carpenter or Special Class Employee) divorce or legally separate from your Spouse	Your former Spouse and/or your Dependent children covered under the Plan	36 months
Your child ceases to meet the Plan's definition of an eligible Dependent child (for example, because of the child's age)	The affected Dependent child who was covered under the Plan	36 months
<p>* Coverage may be continued an additional 11 months (for a total of 29 months) if you or a covered Dependent becomes disabled as determined by the Social Security Administration before or during the first 60 days of COBRA continuation coverage (and you properly notify the Plan). If you were already enrolled in Medicare (Part A or Part B) when your hours of covered work were reduced or terminated, your Dependents may continue COBRA coverage for 18 months (29 in the case of a disability extension) from the date they would have lost coverage because of that Qualifying Event, or 36 months from the date you became enrolled in Medicare, whichever ends later.</p>		

Type of COBRA Continuation Coverage

COBRA continuation coverage includes all current health benefits under the Plan for Active Carpenters and Dependents (medical, Prescription Drug, dental and vision). It does NOT include life

insurance, accidental death and dismemberment benefits or long term disability benefits. Dependent life insurance may be continued after a Qualifying Event, as described under the Special Surviving Dependent Provision for COBRA appearing later in this Chapter.

You and your Dependents **may each choose independently** whether to continue coverage under COBRA.

Health Coverage Option Selection

When the Qualifying Event occurs, a COBRA Qualified Beneficiary can continue coverage only under the health option the Qualified Beneficiary was enrolled in as of the date their coverage would have otherwise ended. The Qualified Beneficiary can change their health coverage option only during the Trust's regular annual Open Enrollment period as explained in "Enrollment" ("When to Make Your Coverage Selections") earlier in this Chapter.

For example, someone enrolled in the Kaiser plan medical option as of the date coverage would otherwise end can continue coverage under COBRA only under that Kaiser Medical Plan until the next annual Open Enrollment period, when a change in health coverage can then be made.

Exceptions are made only if someone is enrolled in an HMO Medical Plan or in-network only Dental plan and moves out of the service area.

IMPORTANT: Notification Requirements

a. Divorce or Legal Separation or a Child Losing Dependent Status

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries **only after** the Administrative Office has been notified (at the address set forth immediately below) that a Qualifying Event has occurred.

When the Qualifying Event is divorce or legal separation of the employee and Spouse or a Dependent child losing eligibility for coverage, **the Active Carpenter, Special Class Employee, Spouse or other Dependent must notify the Administrative Office in writing** of a divorce, legal separation or a child's losing Dependent status under the Plan **within 60 days** from the later of the date that the event occurred or the date coverage would be lost as a result of the event.

The Notice of COBRA Qualifying Event must be received at the following address:

Carpenters Southwest Administrative Office
ATTN: COBRA Department
533 South Fremont Avenue
Los Angeles, CA 90071-1706

If the Administrative Office is not notified in writing within 60 days of the Qualifying Event, the participant(s) whose coverage under the Plan is terminating will not be entitled to continue coverage under COBRA.

b. Death, Termination of Employment, Reduction in Hours

An employer must notify the Administrative Office of an Active Carpenter's or Special Class Employee's death or a Special Class Employee's termination of employment **within 30 days** of the event. (It is suggested that a family member also contact the Administrative Office in the event of the death of the employee.)

The Administrative Office will determine if there has been a termination of employment or reduction of hours that would qualify an Active Carpenter or Special Class Employee for COBRA continuation coverage.

REMINDER: Failure to notify the Administrative Office in a timely fashion may jeopardize an individual's rights to COBRA coverage.

Enrollment Requirements for COBRA

When the Administrative Office is notified of a Qualifying Event, the necessary forms for enrollment in COBRA continuation coverage will be mailed to the Qualified Beneficiary. A COBRA Qualified Beneficiary can enroll in COBRA continuation coverage by completing the COBRA "Election/Rejection" form provided by the Administrative Office **within 60 days** from:

- the date coverage would otherwise terminate, or
- the date the Administrative Office mailed the COBRA Election/Rejection form to the Qualified Beneficiary (if later).

If the election/rejection form is not properly completed and submitted to the Administrative Office within the time limit specified above, the former Eligible Individuals whose coverage under the Plan is terminating will not be entitled to continue coverage under COBRA except as provided under "Special COBRA Enrollment Rights" later in this Chapter.

Duration of COBRA Continuation Coverage

For each Qualified Beneficiary who elects and provides proper payment for COBRA continuation coverage, coverage will begin on the date coverage under the Plan otherwise would have ended. COBRA continuation coverage is a temporary continuation of coverage, as follows:

- When the Qualifying Event is the death of the employee, divorce or legal separation, or a Dependent child losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to **36 months**.
- When the Qualifying Event is the end of employment or reduction in the employee's hours of employment making the employee ineligible for benefits, COBRA continuation coverage lasts for up to **18 months**.

Extending COBRA Duration: There are two primary ways in which an 18-month period of COBRA continuation coverage can be extended.

a. **Disability extension of an 18-month period of COBRA continuation coverage**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Administrative Office in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of **29 months**.

You must make sure that the Administrative Office is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage.

This notice must be sent to the Administrative Office with a copy of the disability determination in a timely manner to preserve your and your family's rights to the disability extension of continuation coverage.

Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage.

- The cost of COBRA Continuation Coverage during the additional 11-month period of COBRA Continuation Coverage **may be 50% higher than the cost for coverage during the first 18-month period.**
- The Administrative Office must also be notified within 30 days of the determination by the Social Security Administration that you are **no longer disabled**.
- In no case is anyone entitled to COBRA Continuation Coverage for more than a total of 36 months.

REMINDER: To be able to have an extension of COBRA from 18 months to 29 months related to a disability, all the following points must be true:

- 1) The COBRA qualifying event is the employee's termination of employment or the employee's reduction in hours causing a loss of coverage;
- 2) The qualified beneficiary is determined by the Social Security Administration (SSA) to have been disabled at any time before or during the first 60 days of an 18-month period of COBRA coverage (and has not been determined to be no longer disabled between the date of the disability determination and the first day of COBRA coverage);
- 3) The qualified beneficiary notifies the Plan about the Social Security Administration (SSA) determination within the latest of one of these timeframes:
 - Within 60 days of electing COBRA if the SSA disability determination effective date was on or before the date of the COBRA qualifying event, or
 - Within 60 days of the date the Qualified Beneficiary received the disability determination notice from the Social Security Administration (SSA) if the SSA disability effective date was after enrollment in COBRA; and
- 4) The qualified beneficiary notifies the Plan of the Social Security Administration (SSA) determination before the end of the 18-month COBRA coverage period.

If these points above are not followed, the Plan is not obligated to extend the COBRA duration from 18 to 29 months.

b. **Second Qualifying Event extension of 18-month period of COBRA continuation coverage**

A Spouse and Dependent Child who already have COBRA coverage, and then experience a second qualifying event, may be entitled to extend their COBRA from 18 or 29 months, to a total of **36 months** of COBRA coverage. This extension is available to the Spouse and Dependent children if the former employee dies or gets divorced or legally separated. The extension is also available to a Dependent child when that child stops being eligible under the Plan as a Dependent child.

In all of these cases, you must make sure that the Administrative Office is notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the Administrative Office in a timely manner to preserve your family's rights to the extension of continuation coverage. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage.

This extended period of COBRA Continuation Coverage is not available to anyone who became a Spouse after the termination of employment or reduction in hours. This extended period of COBRA Continuation Coverage is available to any child(ren) born to, adopted by or placed for adoption with the covered employee during the 18-month period of COBRA Continuation Coverage.

Cost and Payment of COBRA Continuation Coverage

COBRA Qualified Beneficiaries must pay for COBRA continuation coverage. The cost of coverage is based on the Trust's costs to provide coverage to eligible employees and Dependents. The current self-pay rates are included in the COBRA enrollment material sent by the Administrative Office to COBRA Qualified Beneficiaries.

Options for Self-Payment of COBRA Premiums

COBRA premium payments must be made by either a **money order** or a **cashier's check**. Personal checks are not acceptable.

Due Date for Initial Self-Payment of COBRA Premiums

The initial self-payment for COBRA continuation coverage must be submitted to the Administrative Office **within 45 days** from the COBRA Qualified Beneficiary's election date. The initial payment must cover the number of months from the date coverage otherwise would have terminated, including the month in which the initial payment is made.

Payment by money order or cashier's check must be sent or delivered to:

Southwest Carpenters Health and Welfare Trust
ATTN: COBRA Department
533 South Fremont Avenue
Los Angeles, CA 90071-1706

If the initial COBRA self-payment in the proper amount is not submitted to the Administrative Office within the 45-day period described above, the election of COBRA continuation coverage will be automatically revoked and considered void and the participant(s) whose coverage under the Plan is terminating will not be entitled to continue coverage under COBRA.

Example: Your coverage is terminating on February 1. The Administrative Office receives your completed COBRA election form on March 3. Your initial COBRA premium payment must be submitted to the Administrative Office no later than April 17 (hand delivered or postmarked). If you mail your payment on April 17, the amount of your payment must be for at least three (3) months of coverage (February, March and April). Since subsequent payments

should be mailed by the 20th day of the month preceding each coverage month, in this example, it would be recommended that your payment also include the amount due for May coverage.

Due Date for Subsequent Payments of COBRA Premiums

After the initial self-payment is made as outlined above, self-payments must be made monthly to continue COBRA coverage. **Monthly payments should be mailed to the Administrative Office** (address noted above) **by the 20th day of the month preceding each coverage month** to avoid eligibility problems and possible delays in claim payments.

If the Administrative Office does not receive a monthly COBRA premium payment within 30 days of the beginning of the coverage month, COBRA continuation coverage will terminate as of the end of the period for which payment has been made. **Once terminated, COBRA coverage cannot be reinstated.**

Frequently Asked Questions

Q. Will I get a monthly bill for COBRA?

A. No, the Administrative Office will not send monthly bills or warning notices. It is the responsibility of the COBRA Qualified Beneficiary to submit payments when due. The Administrative Office will, however, notify you in writing when your COBRA continuation coverage terminates.

Confirmation of Coverage Before Election or Payment of COBRA Continuation Coverage

If a Health Care Provider requests confirmation of coverage, and you, your Spouse, or Dependent Child(ren) have elected COBRA Continuation Coverage and the amount required for COBRA Continuation Coverage has **not** been paid while the 45-day grace period is still in effect **or** you, your Spouse or Dependent Child(ren) are within the 60-day COBRA election period but have not yet elected COBRA, then COBRA Continuation Coverage will be confirmed.

And, this confirmation will notify the Health Care Provider that:

- the cost of the COBRA Continuation Coverage has not been paid,
- no claims will be paid until the amounts due have been received, and
- the COBRA Continuation Coverage will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

Insufficient Monthly Premium Payment: What If The Full COBRA Premium Payment Is Not Made When Due?

If the Administrative Office receives a **COBRA premium payment that is not for the full amount due**, the Administrative Office will determine if the COBRA premium payment is short by an amount that is significant or not.

A premium payment will be considered to be **significantly short** of the required premium payment if the shortfall **exceeds the lesser of \$50 or 10%** of the required COBRA premium payment.

- **If there is a significant premium shortfall**, then COBRA continuation coverage will end as of the date for which the last full COBRA premium payment was made.
- **If there is not a significant premium shortfall**, the Administrative Office will notify the Qualified Beneficiary of the deficient amount and allow a reasonable period of 30 days to pay the shortfall.

If the shortfall is paid in the 30-day time period then COBRA continuation coverage will continue for the month in which the shortfall occurred.

If the shortfall is not paid in the 30-day time period then COBRA continuation coverage will end as of the date for which the last full COBRA premium payment was made (which may result in a mid-month termination of COBRA coverage).

Special Surviving Dependents Provision Related to COBRA

If an Active Carpenter, while eligible under the Plan by virtue of work hours, dies as the result of a work-related event that occurred while on the job working for a Contributing Employer, the Active Carpenter's surviving Dependents will be entitled to a subsidy of their self-pay COBRA premium, in the event they timely elect COBRA coverage as a result of the Qualifying Event.

In the event of such an election, the surviving Dependents will not be required to make premium payments for COBRA coverage until the earlier of the first day of the first month following:

- a. the expiration of 24 months following such Qualifying Event,
- b. the remarriage of the surviving Spouse, or
- c. the surviving Dependent child no longer meets the Plan's definition of Dependent child (see the Glossary Chapter).

Nothing in this provision will be interpreted as extending a surviving Dependent's COBRA continuation coverage under the Plan beyond the date such coverage otherwise would end absent this special surviving Dependent provision.

A surviving Dependent or their legal guardian must **notify the Administrative Office in writing of the remarriage of a surviving Spouse or cessation of Dependent status** within ten (10) days of such an event. **Failure to do so** will result in immediate forfeiture of Eligible Individual status and subject the party responsible for such notice to the contractual obligation (in consideration of the acceptance of Eligible Individual status) to repay the Trust for any benefits received, and costs (including reasonable attorney fees) of collection of same.

The Administrative Office will not furnish any notices to surviving Dependents with respect to the requirement to commence self-pay COBRA premium payments, except at the time of the Administrative Office's furnishing of the original COBRA election. At such time, a notice describing the requirements for payment of premiums following the completion of the subsidy period will be provided.

Dependent life insurance benefits will continue to be provided to a surviving Dependent during the months the COBRA self-pay premium is subsidized under this special provision.

COBRA Enrollment Rights

Open Enrollment

The Open Enrollment period is held each year (the Administrative Office mails an announcement explaining when the Open Enrollment period will occur and the duration of time for Open Enrollment). COBRA Qualified Beneficiaries are entitled to participate in Open Enrollment. At such time a COBRA Qualified Beneficiary may change (add or delete) medical, dental and/or vision coverage options, when such changes are similarly permitted for Active employees.

There are three **Special Enrollment opportunities for COBRA Beneficiaries**, explained below:

a. **New Dependent(s) Acquired During COBRA coverage.**

If you acquire a new Dependent through marriage, birth, adoption, or placement for adoption while you are enrolled in COBRA continuation coverage, you may add that Dependent for coverage.

- A child who becomes a Dependent Child by birth, adoption or placement for adoption with the covered Qualified Beneficiary during a period of COBRA Continuation Coverage is also a Qualified Beneficiary with rights under COBRA as an eligible Dependent child.
- A child of the covered employee who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO), during the employee's period of employment, is entitled to the same rights under COBRA as an eligible Dependent child.
- A person who becomes the new Spouse of an existing COBRA participant during a period of COBRA Continuation Coverage may be added to the COBRA coverage of the existing COBRA participant but is not a "Qualified Beneficiary." For example, if you have five months of COBRA left and you get married, you can enroll your new legal Spouse for five months of COBRA coverage. If the existing COBRA participant dies or divorces before the expiration of the maximum COBRA coverage period, the new Spouse is not entitled to elect COBRA.

To enroll your new Dependent for COBRA coverage, you must notify the Administrative Office within **31 days** of acquiring the new Dependent through marriage, birth or adoption. There may be a change in your COBRA premium amount in order to cover the new Dependent.

b. **Group Health Plan Coverage Loss.**

If, while you are enrolled in COBRA continuation coverage, your Spouse or Dependent **loses coverage under another group health plan**, you may enroll the Spouse or Dependent child for coverage for the balance of the period of COBRA continuation coverage. The Spouse or Dependent child must have been eligible for COBRA coverage, but not enrolled. When COBRA enrollment was offered and declined, the Spouse or Dependent child must have been covered under another group health plan or had other health insurance coverage.

You must enroll the Spouse or Dependent child **within 31 days** after the termination of the other coverage. Adding a Spouse or Dependent child may cause an increase in the amount you must pay for COBRA continuation coverage.

The loss of coverage must be due to: 1) exhaustion of COBRA continuation coverage under another plan, 2) loss of eligibility for the coverage, 3) employer contributions toward the other coverage being terminated, 4) moving out of an HMO Medical Plan service area if HMO coverage terminated for that reason and, for group coverage, no other option is available under the other plan, or 5) the other plan ceases to offer coverage to a group of similarly situated individuals.

Loss of eligibility does not include a loss due to failure of the individual or Participant to pay premiums on a timely basis or termination of coverage for cause.

c. **Medicaid or CHIP Events.**

If a Qualified Beneficiary or their Dependent(s) loses coverage through Medicaid or CHIP, or becomes eligible for a premium assistance program through Medicaid or CHIP, the Qualified Beneficiary may enroll themselves or Dependent(s) for COBRA continuation coverage for the balance of the period of COBRA continuation coverage. The Qualified Beneficiary or

Dependent(s) must have been eligible for COBRA coverage as of the date of the initial Qualifying Event, but have not enrolled.

The Qualified Beneficiary must enroll themselves or their Dependent within **60 days** after the date Medicaid or CHIP coverage is lost or the date the Qualified Beneficiary or their Dependent(s) is determined to be eligible for premium assistance through Medicaid or CHIP, whichever is applicable.

Health Coverage Tax Credit (HCTC)

The Trade Act of 2002 created a tax credit (called the Health Coverage Tax Credit or HCTC) for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). Eligible Individuals can either take a tax credit or get advance payment of 72.5% of premiums paid for qualified health insurance including COBRA. While the HCTC expired on January 1, 2014, it was reinstated to be effective for coverage periods through 2019. For more information, visit, www.irs.gov/HCTC.

Termination of COBRA Continuation Coverage

Once COBRA continuation coverage has been elected, it will be terminated on the occurrence of **any** of the following events:

- a. The first day of the month for which you do not submit the COBRA premium **in full and within the required time period**.
- b. The date on which the Plan is terminated.
- c. The date, after the date of the COBRA election, on which you or your eligible Dependent(s) first become covered by another group health plan, and that plan does not contain any legally applicable exclusion or limitation with respect to a preexisting condition that the covered person may have. If you think this exception applies to you, contact the Administrative Office immediately and the staff will advise you on what documentation is necessary.
- d. The date, after the date of the COBRA election, on which you or your eligible Dependent(s) first become entitled to Medicare (usually age 65).
- e. The date the Contributing Employer who last employed the Active Carpenter or Special Class Employee before the Qualifying Event stops contributing to the Plan and establishes one or more group health plans covering a significant number of the employer's employees formerly covered under this Plan or starts contributing to another multiemployer plan that is a group health plan.
- f. (For COBRA Qualified Beneficiaries covered under the special 11-month extension for disabled individuals) when the special 11-month extension expires or, if sooner, 30 days after the month in which Social Security determines that the Qualified Beneficiary is no longer disabled. The COBRA Qualified Beneficiary must notify the Administrative Office immediately upon receipt of such a Social Security determination.

Notice of Early Termination of COBRA Continuation Coverage

The Plan will notify a Qualified Beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the Qualifying Event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the Qualified Beneficiary may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the Administrative Office determines that COBRA coverage will terminate early.

Once COBRA coverage terminates early it cannot be reinstated.

Notice of Unavailability of COBRA Coverage

In the event the Plan is notified of a Qualifying Event but determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent, by the Administrative Office an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

California COBRA Law (Applicable Only to HMO Participants in California)

If you are a COBRA participant enrolled in a California HMO, a California law known as “Cal-COBRA” has two provisions that may extend the length of time you may continue coverage. These laws apply only to your HMO medical coverage:

If your Qualifying Event was a reduction in or termination of your hours of covered work and you exhaust the 18 months of COBRA continuation coverage normally available after such a Qualifying Event (or the 29 months available in the case of disability), you may continue your HMO medical coverage an additional 18 months (or an additional 7 months in the case of a disability). To take advantage of either of these provisions, your continuation coverage must be through the same HMO Medical plan. For more information, contact your HMO Medical Plan.

Conversion to Individual Coverage (Applicable Only to HMO Participants)

Under certain circumstances, employees and eligible family members whose coverage through an HMO Medical Plan ends are allowed to purchase individual conversion coverage through their HMO without evidence of insurability. Individuals must apply to the HMO for conversion coverage and pay the premium within **31 days** of the loss of their coverage. To take advantage of this provision, your individual coverage must be through the same HMO Medical plan. For more information, contact your HMO.

Appealing an Adverse Determination Related to COBRA

If an individual receives an adverse determination (denial) related to a request for eligibility for COBRA (such as with a Notice of Unavailability of COBRA), a request for extension of COBRA for a disability, a request for extension of COBRA for a second qualifying event, or a notice of early termination of COBRA, the individual is permitted to appeal to the Plan.

To request an appeal, follow this process:

- a. Send a written request for an appeal to the Administrative Office within 30 days of the date you received the adverse determination letter.
- b. Explain why you disagree with the adverse determination. Provide any additional information you want considered during the appeal process. Include the most current name and address of each individual affected by the adverse determination.
- c. **If an appeal is filed with the Plan more than 30 days before the next Board meeting**, the review will occur at the next Board meeting date. **If an appeal is filed with the Plan within 30 days of the next Board meeting**, the Board review will occur no later than the second meeting following receipt of the appeal.
- d. If special circumstances (such as the need to hold a hearing) require a further extension of time the Board’s review will occur at the third meeting following receipt of the appeal. If such an extension is necessary the Plan will provide to you a Notice of Extension describing the special circumstances and date the benefit determination will be made.
- e. After the Board makes their decision on the appeal, you will be notified of the benefit determination on the appeal no later than 5 calendar days after the benefit determination is made.

The appeal response will be sent to the address provided by the individual who appealed. This concludes the COBRA appeal process.

Note that a claim for reimbursement of health expenses would follow the claim appeal processes outlined in the Chapter 15 of this document.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Administrative Office informed of any changes in the addresses or Dependent status of family members, including births, deaths, or divorces. You should also keep a copy, for your records, of any notices you send to the Administrative Office.

If You Have Questions About COBRA

If you have questions about your COBRA continuation coverage, you should contact the Eligibility Department of the Administrative Office or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/agencies/ebsa/about-ebsa/about-us/regional-offices.

IMPORTANT COBRA REMINDERS

- ✓ **There will be no invoices or reminders for COBRA premium payments.**
- ✓ **You are responsible for making sure that timely COBRA premium payments are made to the Administrative Office in full and on time.**
- ✓ **If you fail to make a periodic COBRA premium payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.**

Chapter 4: THE ANTHEM MEDICAL PPO PLAN (including Preauthorization)

This Chapter includes information on:

- How the Anthem Medical PPO Plan works
- Cost-sharing: annual Deductibles, Copayment, and Coinsurance
- Annual Out-of-Pocket Limit
- Preauthorization
- Certain Drugs Mandated to be Covered
- Special Notices
- What's Covered

The information in this Chapter applies to you only if you are an Eligible Individual enrolled in the **Anthem Medical PPO Plan**. If you are enrolled in one of the other medical plan options instead, see the separate booklet(s) issued by the HMO Medical Plan for information on your medical benefits.

How Does The Anthem Medical PPO Plan Work?

Eligible Medical Expenses

You are covered for expenses you incur for most, but not all, medical services and supplies. An expense for which you are covered is called an “Eligible Medical Expense.” Eligible Medical Expenses are generally described in the Schedule of Medical Benefits. Eligible Medical Expenses are determined by the Plan Administrator or its Delegate, and are limited to those that are:

- a. **“Medically Necessary,”** but only to the extent that the charges are **“Allowed Charges”** (as those terms are defined in the Glossary Chapter of this document). The fact that a Physician prescribes or orders the service does not, in itself, make it Medically Necessary or a covered expense; and
- b. **not services or supplies that are excluded** from coverage (as provided in the Exclusions Chapter 6 of this document); and
- c. **not services or supplies in excess of a Maximum Plan Benefit** as shown in the Schedule of Medical Benefits in Chapter 5; and
- d. ordered by a Physician or Health Care Practitioner **for the diagnosis or treatment of an injury or illness** (except where wellness/Preventive Services are payable by the Plan as noted in the Schedule of Medical Benefits in this document); and
- e. **expenses incurred while you are covered under this Plan.** An expense is incurred on the date you receive the service or supply for which the charge is made.

Generally, **the Plan will not reimburse you for all Eligible Medical Expenses.** Usually, you will have some cost-sharing, meaning you will need to satisfy some Deductibles and pay some Coinsurance, or make some Copayments toward the amounts you incur that are Eligible Medical Expenses. However, once you have reached the Out-of-Pocket cost-sharing limit, applicable to Deductibles, Copayments and Coinsurance for in-network covered services, no further cost-sharing

will apply for the Calendar Year. The **Plan also requires preauthorization** (pre-approval) for certain services as explained in this Chapter.

The Anthem Medical PPO Plan does not require the selection or designation of a primary care provider. You have the ability to visit any PPO or non-PPO Provider; however, Plan **benefits are generally less when you use a non-PPO Provider**. There is also no requirement to obtain a referral or preauthorization before visiting an OB/GYN provider.

Preferred Provider Organization “PPO” (Network Health Care Provider Services)

As noted in the Schedule of Medical Benefits in Chapter 5, if an Eligible Individual enrolled in the Anthem Medical PPO Plan obtains services from a PPO provider (meaning a provider contracted with Anthem), the percentage of Allowable Charges payable by the Plan is generally much higher.

Network providers are also called PPO providers, preferred providers, contracted providers or participating providers.

What Is a PPO?

“PPO” means “Preferred Provider Organization.” A PPO is an organization who contracts with Hospitals, Physicians, Laboratories, and other health care providers to provide eligible members with health care at specified discounted prices compared to the provider’s usual billed charges. The PPO helps you and the Trust save money.

The Trust contracts with Anthem Blue Cross for access to its Prudent Buyer PPO network in California and the Blue Card PPO network in all other geographical areas of the U.S.

How Does the PPO Work?

When you need to see a Physician, simply select one from the PPO’s preferred providers listed under the Anthem Prudent Buyer network at www.anthem.com or call toll-free (833) 224-6930, or under the Blue Card program at the phone number listed on your ID card.

Before your appointment, call the provider’s office to verify that the provider is still in the PPO network on the date you plan to visit. It is recommended that you keep a record of the date, time and name of the person at the provider’s office to whom you spoke.

When you visit the PPO Physician, show the receptionist your Southwest Carpenters Health and Welfare Trust ID card. If you are referred to a specialist, Hospital, laboratory or other provider, remind your Physician that you want to use PPO providers. If your Physician prescribes a CAT scan, MRI scan, laboratory test, Durable Medical Equipment, outpatient Surgery or home health care, have your Physician arrange the tests, equipment, or care through a PPO provider.

Certain services require preauthorization (pre-approval). See the “Preauthorization” section later in this Chapter for more information.

You do not have to sign up with a particular Physician or medical group and use them exclusively for your medical needs. You may use the services of any PPO provider or non-PPO provider whenever you choose, but your costs will be higher if you use the services of a non-PPO provider.

Why Use PPO Providers?

PPO providers save you money, as follows:

- The Plan’s benefit reimbursement for your covered services is generally much higher when you use a PPO provider.
- Certain dollar limits set by the Plan such as the \$5,000 limit for Hospital outpatient Surgery, do not apply when you use a PPO Provider.

- The Plan’s Out-of-Pocket Limit feature applies when you use a PPO provider. The Out-of-Pocket Limit feature does not apply when you use a non-PPO provider. The Out-of-Pocket Limit is the most you pay in cost-sharing (Deductibles, Copayments and Coinsurance) for covered Essential Health Benefits received from Network providers during a one-year period (the Calendar Year) before your Anthem Medical PPO Plan starts to pay 100%.
- PPO Physicians and other network health care providers have agreed to provide medical services and supplies to Eligible Individuals at specified discounted fees, thus limiting your Out-of-Pocket costs.
- PPO providers have agreed to send your claims directly to the Claims Administrator for processing. You simply give the provider your ID card that explains where they send their billing. Once your claim is processed, you will receive an Explanation of Benefits (EOB) form indicating what (if any) you owe to the PPO provider.

Out-of-Network Providers

(also called Non-PPO, Non-Network, Non-Preferred, Non-Participating, or Non-Contracted)

Out-of-Network refers to providers who are not contracted with the Anthem Medical PPO Plan’s Network and who do not generally offer any fee discount to the Plan participant or to the Plan.

Out-of-Network Health Care Providers may bill you a non-discounted amount for any balance that may be due in addition to the Allowed charge payable by the Plan, also called Balance Billing. **To avoid Balance Billing, use PPO Network providers.**

Important Note

If you use an out-of-network (non-PPO) provider, it is likely that their charges will exceed what is allowed as payment by the Plan, except in the case of a medical Emergency in an Emergency room. Refer to the definition of Allowable Charges and Emergency in the Glossary. In addition to any cost-sharing (such as Deductibles, Copayments and Coinsurance) you have when using a non-PPO provider, you are also responsible for payment of all charges in excess of the Plan’s Allowable Charges. This applies to any non-PPO provider used for any reason.

Special Reimbursement Provisions for Out-of-Network Providers

If you are treated or confined at a PPO Network facility, but an Out-of-Network Health Care Provider (outside the patient’s control) performed certain Medically Necessary covered services (such as professional fees for radiology, anesthesia, assistant surgeon, pathology, laboratory, and emergency room services), then the Plan will pay eligible claims submitted by the Out-of-Network provider as if the care was provided by a Network PPO Provider. This includes applicable amounts for deductibles, coinsurance, copays, and the Out-of-Pocket Limit. The allowance for the bills will be reimbursed according to the Allowed Charge for Out-of-Network PPO Providers. Allowed charge is defined in the Definitions chapter of this document.

The Plan Administrator or its designee determines if and when the following special reimbursement circumstances apply to a claim after the normal claim adjudication processes have been followed/investigated. Medical records may be requested in order to assist with a determination on the need for a special reimbursement provision.

Frequently Asked Questions

Q. Will the Plan cover me for health care I receive in another country?

A. No, unless the health care is for Emergency treatment received while you are traveling on business or vacation. Refer to Chapter 6 under “Expenses Incurred Outside the United States” for more details.

What Is Cost-Sharing?

Cost-sharing refers to how you and the Plan split the cost for covered Anthem Medical PPO Plan benefits. There are three types of cost-sharing under the Anthem Medical PPO Plan: Deductibles, Copayments/Copays and Coinsurance. These are explained below in more detail and on the Schedule of Medical Benefits in Chapter 5.

Cost-sharing does not refer to premiums/contributions for coverage, Balance Billing amounts, or non-covered/excluded medical expenses.

What Is The Deductible?

The Deductible is the amount you need to pay each Calendar Year before the Plan starts paying Allowable Charges for covered services or supplies. There are **two types of annual Deductibles**: an Individual Deductible and a Family Deductible.

- The **Individual Deductible** is the maximum amount one covered person has to pay toward Eligible Medical Expenses before Plan benefits begin for that covered person.
- The **Family Deductible** is the maximum amount that a family is responsible for paying before the Plan begins to pay Eligible Medical Expenses for anyone in the family (covered person or Dependent) who has not already met the Individual Deductible. Once the family Deductible is met for the year, the individual Deductible does not have to be met for any remaining individuals in that family in that year. The family Deductible can be met by any combination of amounts from any family member.

There is an annual Deductible when using network providers and a separate annual Deductible when using non-network providers. Note that the Network and Out-of-Network Deductibles **are not interchangeable**, meaning that you may not use a portion of a network Deductible to meet an out-of-network Deductible and vice versa.

The amount of the Anthem Medical PPO Plan's Deductible is explained in the Schedule of Medical Benefits in Chapter 5.

Deductibles are applied to the Eligible Medical Expenses in the order in which claims are processed by the Plan. The amount applied to a Deductible is the lesser of billed charges or the amount considered to be an Allowed Charge under this Plan.

Only Eligible Medical Expenses can be used to satisfy the Plan's Deductibles. As a result, Non-Eligible Medical Expenses described above do not count toward the Deductibles, meaning that non-covered expenses or expenses in excess of Allowed Charges cannot be used to satisfy the Deductible. (Allowed Charge is defined in the Glossary chapter).

Services and Supplies for Which the Deductible is Waived

Certain Eligible Medical Expenses are not subject to Deductibles. These expenses may be covered 100% by the Plan, or they may be subject to Copayments, as explained on the Schedule of Medical Benefits in Chapter 5.

You do NOT have to meet the Deductible before the Plan starts paying benefits for certain services, explained on the Schedule of Medical Benefits, such as:

- Preventive Care Services delivered by a PPO Provider (see the Glossary Chapter for a definition of Preventive Care Services)
- Outpatient Prescription Drugs (e.g. retail, mail order, specialty Drugs)

- Ambulance for Emergency medical transportation
- Telemedicine services (online visit with a health care professional via video live chat)
- The first 30 days of confinement in a Skilled Nursing Facility (SNF)

End-of-Year Deductible Carryover Provision

Any covered expenses incurred in the last 3 months of a Calendar Year that are applied toward the Deductible will also be applied toward the Deductible for the following year. This prevents you from having to meet the Deductible late in one Calendar Year and then having to meet it soon again in the following year.

Common Accident Deductible Provision

If two or more family members are injured in the same accident, the Deductible for all Allowable Charges arising out of the accident during the Calendar Year in which the accident occurs is the individual Deductible amount. For the amount of the annual Deductible, see the Schedule of Medical Benefits in Chapter 5.

What Is Coinsurance?

Coinsurance refers to how you and the Anthem Medical PPO Plan will split the cost of certain covered medical expenses. Once you've met your annual Deductible, the Plan generally pays a percentage of the Eligible Medical Expenses, and you (not the Plan) are responsible for paying the rest. The part you pay is called the Coinsurance. The Coinsurance related to a covered benefit is described on the Schedule of Medical Benefits.

If you use the services of a Health Care Provider who is a member of the Plan's PPO network (a Network Provider), you will be responsible for paying less money (lower Coinsurance) out of your pocket.

What Is A Copayment (Copay)?

A **Copayment** (or Copay, as it is sometimes called) is a set dollar amount you (and not the Plan) are responsible for paying when you incur certain Eligible Medical Expenses. The Plan's Copayments are indicated on the Schedule of Medical Benefits. Copayments **do accumulate** to meet the annual Out-of-Pocket Limit under the Anthem Medical PPO Plan (see the section on Out-of-Pocket Limit below).

What Is The Annual Out-Of-Pocket Limit?

The Out-of-Pocket Limit is the most you pay in cost-sharing (Deductibles, Copayments and Coinsurance) for covered Essential Health Benefits received from Network providers during a one-year period (the Calendar Year) before your Anthem Medical PPO Plan starts to pay 100%.

Under the Anthem Medical PPO Plan there are two separate annual Out-of-Pocket Limits: one for Medical plan benefits not including outpatient Prescription Drugs, and a separate Out-of-Pocket Limit just for outpatient Prescription Drugs. Together these limits do not exceed the total Out-of-Pocket Limit set by the federal Affordable Care Act (ACA) regulations. The amount of the annual Out-of-Pocket Limit is explained on the Schedule of Medical Benefits in Chapter 5.

Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan. The family Out-of-Pocket Limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than

this Plan’s “per person in a family” annual Out-of-Pocket Limit (as explained in the Schedule of Medical Benefits).

There is **no Out-of-Pocket Limit on the use of Out-of-Network (non-network, non-PPO) providers**, except that Emergency Services performed in an Out-of-Network Emergency Room will accumulate to meet the Network Out-of-Pocket Limit.

The following expenses do not accumulate to meet the annual Out-of-Pocket Limit:

- a. All services and supplies provided by Non-PPO (out-of-network) providers, except in cases involving Emergency Services performed in an Out-of-Network Emergency Room which do accumulate to the In-network Out-of-Pocket Limit
- b. Expenses that are not considered to be Essential Health Benefits (defined in the Glossary chapter), such as Spinal Manipulation/Chiropractic treatment
- c. Premiums and/or self-payment contributions for coverage
- d. Amounts you pay for non-covered services
- e. Charges above what the Plan allows (above the Allowable Charge, as defined in the Glossary Chapter)
- f. Charges in excess of the Anthem Medical PPO Plan’s maximum benefits
- g. Dental Plan or Vision Plan expenses
- h. Any cost-sharing under the outpatient Prescription Drug Benefit does not apply to the Anthem Medical PPO Plan Out-of-Pocket Limit, **but does apply** to meet the separate annual Outpatient Prescription Drug Out-of-Pocket Limit.

The Anthem Medical PPO Plan Out-of-Pocket Limit does not include/accumulate outpatient Prescription Drug benefits, while the Outpatient Prescription Drug Out-of-Pocket Limit does not include/accumulate other Medical plan benefits.

The Outpatient Prescription Drug Out-of-Pocket Limit does not accumulate Drug costs related to amounts you pay for Prescription Drugs obtained at walk-in retail pharmacies after the second fill of a maintenance Drug.

Refer to Chapter 5 for details on the Out-of-Pocket Limit that applies to the medical plan and separately to outpatient Prescription Drug benefits.

Maximum Plan Benefit Limits

Types of Maximum Plan Benefits: There are three types of maximum amounts of benefits payable by the Anthem Medical PPO Plan on account of medical expenses incurred by a covered Plan Participant under this Plan. They are: Lifetime Maximum Plan Benefit; Limited Overall Maximum Plan Benefit; and Annual Maximum Plan Benefit.

- **Lifetime Maximum Plan Benefit:** A Lifetime Maximum Plan Benefit is the maximum amount of benefits payable by this Plan during the entire time a Plan Participant is covered under this Plan. Once the Plan has paid the Lifetime Maximum Plan Benefit for a Covered Individual, no further Plan benefits will be paid on account of that person.

The description of the maximum as a “Lifetime” maximum does not mean, nor should it be construed to mean, that the Plan has any obligation to pay any benefits during the lifetime of the Plan Participant after coverage terminates.

The benefits that include a Lifetime Maximum are shown in the Schedule of Medical Benefits, such as outpatient speech therapy with a lifetime visit maximum.

In accordance with federal law, there is no overall lifetime maximum on Anthem Medical PPO Plan benefits or on outpatient Prescription Drug benefits.

- **Limited Overall Maximum Plan Benefit:** Certain Plan benefits are subject to limitations that are not considered Lifetime maximums or Annual maximums. These other types of maximums are referred to under this Plan as Limited Overall Maximums. An example would be a limit per operative session for non-network use of an outpatient Surgery facility. The services or supplies that are subject to Limited Overall Maximum Plan Benefits and the amounts of these maximums are identified in the Schedule of Medical Benefits.
- **Annual Maximum Plan Benefit:** Plan benefits for certain Eligible Medical Expenses are subject to Annual Maximums per Covered Individual or family during each Calendar Year. Once the Plan has paid the Annual Maximum Plan Benefit for any of those services or supplies on behalf of any Covered Individual or family, no further Plan benefits will be paid for those services or supplies on account of that Individual or family for the balance of the Calendar Year. The services or supplies that are subject to an Annual Maximum Plan Benefit are identified in the Schedule of Medical Benefits, such as outpatient physical therapy.

Preauthorization

To enable the Plan to provide coverage in a cost-effective way, the Plan has adopted a Utilization Management (UM) Program designed to help control increasing health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result. By doing this, the Trust is better able to afford to maintain the Plan and all its benefits. If you follow the procedures of the Plan's Utilization Management Program, you may avoid some Out-of-Pocket costs. **However, if you don't follow these procedures, the Plan provides reduced benefits, and you'll be responsible for paying more out of your own pocket.**

Preauthorization (preapproval) is **required** for some benefits under the Anthem Medical PPO Plan in order **to avoid a financial penalty or non-payment.**

There are three Preauthorization Program administrators that perform preauthorization for the Medical Plan: for preauthorization of medical plan services, contact Anthem Blue Cross at (800) 274-7767, and for preauthorization of certain outpatient Drugs, contact Express Scripts (ESI) at 1-800-753-2851 or Accredo for specialty Drugs at 1-800-803-2523. More contact information is listed on the Quick Reference Chart in the front of this document.

The health care professionals at these Preauthorization Programs focus their review on the necessity and appropriateness of services/treatment and necessity of proposed medical, surgical, and Prescription Drug services. In carrying out its responsibilities under the Plan, the Preauthorization Program has been given discretionary authority by the Plan Administrator to determine if a course of care or treatment is Medically Necessary with respect to the patient's condition and within the terms and provisions of this Plan.

Preauthorization (Preapproval)

Preauthorization means contacting AIM Specialty Health for certain medical plan benefits (or for Drugs, contacting Express Scripts or Accredo Specialty Pharmacy) to give certain information **before** services are provided or obtained so these programs can determine whether or not a proposed treatment or service or outpatient Drug will be Medically Necessary and appropriate for you.

**REMINDER: The appropriate Preauthorization Program must give prior approval BEFORE the following treatment/services/outpatient Drugs are delivered.
For failure to obtain preauthorization, no benefits are payable.**

Preauthorization is required for the services in the chart below:

PREAUTHORIZATION IS REQUIRED FOR THESE SERVICES

The following services and items require preauthorization by contacting the Preauthorization Program through AIM Specialty Health (listed on the Quick Reference Chart in the front of this document).

- a. **Inpatient Hospital admissions (Non-Emergency) for medical, surgical, transplants, mental health and/or Substance Use Disorder treatment.**
(Note: for delivery of a child, preauthorization is required only for Hospital stays that last or are expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section.)
- b. **Referral to an Out-of-Network provider or facility**
- c. **Bariatric (weight reduction) Surgery**
- d. **Cosmetic procedures**
- e. **Home health care and Home infusion therapy services**
- f. **Hospice care**
- g. **Anesthesia services in connection with dental care**
- h. **PET scans**
- i. Certain **Durable Medical Equipment (DME) including:** insulin pumps, wheelchairs, wheeled mobility devices, motor scooters, speech augmentation/speech generating devices, bone growth stimulators, electrical stimulators, high frequency chest compression devices for airway clearance, pneumatic compression devices such as used for lymphedema, and standing frames.
- j. **Transplant services** including pre-transplant diagnostic work up and any transplant-related travel expenses.
- k. Admission to a **Skilled nursing facility (SNF), and Inpatient Rehabilitation admission**
- l. **Non-Emergency medical transportation**
- m. Note: Network providers also have a list of services they must preauthorize with their contracted network administrator.

The following outpatient Drugs require preauthorization by contacting Express Scripts (ESI), or Accredo Specialty Pharmacy (both listed on the Quick Reference Chart in the front of this document).

- a. **Certain outpatient Prescription Drugs require preauthorization,** to avoid non-payment, by contacting Express Scripts.
- b. **Certain outpatient Specialty Medication requires preauthorization,** to avoid non-payment, by contacting Accredo Specialty Pharmacy.

Preauthorization does not mean benefits are payable in all cases.

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

For failure to obtain preauthorization, no benefits are payable.

When preauthorization occurs, the Appropriate Preauthorization Program will advise you whether the proposed treatment, supply or Drug is covered, and whether you are seeking care through a network provider. They may also provide you with an explanation of the amount of benefits available to you.

How to Request Preauthorization

As soon as any of the above listed items are proposed by your Physician, advise your provider that **preauthorization is required for certain services and outpatient Drugs**.

You or your Health Care Provider must call the Appropriate Preauthorization Program (see the contact list chart on the next page) to start the preauthorization process.

1. **Preauthorization for elective (Non-Emergency) services should be started with the Appropriate Preauthorization Program at least 10 days before the expected date of service or Drug start date.**
2. Be prepared to provide all of the following information to the Appropriate Preauthorization Program: the Fund's name, employee's name, patient's name, address, and phone number and social security number; Health Care Provider's name, and phone number or address; the name of any Hospital or outpatient facility or any other Health Care Provider that will be providing services; the reason for the health care services, supplies or Drugs; and the proposed date for performing the services, providing the supplies, or starting the Drug(s).
3. When calling to preauthorize, **if the preauthorization review process was not properly followed** the requestor will be notified as soon as possible but no later than 5 calendar days after the preauthorization request.
4. If additional information is needed, the Appropriate Preauthorization Program will advise the requestor. The Appropriate Preauthorization Program will review the information provided, and will let you, your Health Care Provider and the Hospital or other Health Care Provider, and the Claims Administrator know whether or not the proposed health care services have been approved.

The Appropriate Preauthorization Program will usually respond to your treating Health Care Provider **by telephone within 3 working days (but no later than 15 calendar days) after it receives the preauthorized request and any required medical records and/or information**, and its determination will then be confirmed in writing.
5. **Note that an approved preauthorization does not guarantee payment of benefits.** This could be for a variety of reasons such as: the information submitted during preauthorization process varies from the actual services performed on the date of service, the service performed is not a covered benefit, and/or you are ineligible for benefits on the actual date of service.
6. If your admission, service, or Drug is not approved, you and your Health Care Provider may be given recommendations for alternative treatment. You may also pursue an appeal. See the Claim Filing and Claim Appeal Chapter regarding appealing a denial of a preauthorization (preservice) request.

The ordering provider, Hospital or attending Physician ("requesting provider") is to get in touch with Anthem to ask for a preauthorization. However, you may request preauthorization or you may **choose an Authorized Representative** to act on your behalf to request preauthorization.

The Authorized Representative can be anyone who is 18 years of age or older who you designate to act for you. To appoint an Authorized Representative, contact the appropriate Preauthorization Program.

See the chart below for ways to request preauthorization:

Appropriate Preauthorization Program Contact List		
For preauthorization of certain medical plan services	For preauthorization of certain outpatient Prescription Drugs	For preauthorization of certain outpatient Specialty Prescription Drugs
Call or Mail the preauthorization request to:	Call:	Call:
<p>AIM Specialty Health toll-free at 1-877-291-0360.</p> <p>Or, at least 10 days before undergoing the proposed service, mail to Anthem Blue Cross, Attention: Preauthorization Department 2000 Corporate Center Drive CANPA-000 Newbury Park, CA 91320</p>	<p>Express Scripts Inc (ESI) (The Plan's Pharmacy Benefit Manager – PBM) at 1-800-753-2851.</p>	<p>Accredo Specialty Pharmacy at 1-800-803-2523.</p>

For more information about the time frames for responding to requests for required preauthorization and for information on how you can appeal if you disagree with the decision made on a required preauthorization, see the entries for “preservice” claims in “Claim Filing and Claim Appeals” Chapter.

Restrictions and Limitations of the Utilization Management Program

- a. The fact that your Health Care Provider recommends Surgery, Hospitalization, confinement in a Health Care Facility, or that your Health Care Provider proposes or provides any other medical services or supplies doesn’t mean that the recommended services or supplies will be an eligible expense or be considered Medically Necessary for determining coverage under the Medical Plan.
- b. The Utilization Management Program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. Anthem’s certification that a service is Medically Necessary doesn’t mean that a benefit payment is guaranteed. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan as described in this document. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered or if the services were not covered by the Plan either in whole or in part.
- c. All treatment decisions rest with you and your Health Care Provider. You should follow whatever course of treatment you and your Health Care Provider believes to be the most appropriate, even if the Appropriate Preauthorization Program does not certify a proposed Surgery/treatment/service/drug or admission as Medically Necessary or as an eligible expense. However, the benefits payable by the Plan may be affected by the determination of the Appropriate Preauthorization Program.
- d. With respect to the administration of this Plan, the Trust Fund and Anthem are not engaged in the practice of medicine, and none of them takes responsibility either for the quality of health care services actually provided, even if they have been certified by Anthem as Medically Necessary, or for the results if the patient chooses to receive health care services that have not been certified by Anthem as Medically Necessary.

- e. **Preauthorization of a service does not guarantee that the Plan will pay benefits for that service** because, other factors, such as ineligibility for coverage on the actual date of service, the information submitted during preauthorization varies from the actual services performed on the date of service, and/or the service performed is not a covered benefit, may be a factor in non-payment of a service.

Individual Case Management

If you have a serious injury or health issue, the Anthem nurse case managers are available to help, at no added cost to you. While the case managers may automatically contact you, you can also call the Anthem member/customer service phone number on your ID card to reach a case manager.

A Hospital stay or long-term health problem can turn your life upside down. You may need to make some tough choices. And you may feel overwhelmed with new information and not sure where to get help and support.

Anthem has a team of Registered Nurses, supported by clinical experts, who are trained to help during these stressful times. These case management nurses are your advocates to help you get well. Their goal is to understand your needs from all angles and help you get the best care possible.

For instance, depending on your needs, a case management nurse might help you:

- Find out more about your health issue and your treatment options.
- Talk with your doctors and the rest of your health care team — and encourage them to talk with each other.
- Review your health plan to help you save money and get the most value from the Plan.
- Connect with resources near you, like home care services and community health programs.
- Take steps to make healthy changes in your life.

Keep in mind that the case manager does not provide hands-on care to you. It's up to your doctors and the rest of your health care team to do that. But the case manager nurse can work with you and your team to keep the focus where it belongs: helping you manage your health and feel better.

Special Notices

Newborns' and Mothers' Health Protection Act

Federal law guarantees certain rights to women. Under the **Newborns' and Mothers' Health Protection Act of 1996**, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (for example, your Physician), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of benefits or Out-of-Pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

Women’s Health and Cancer Rights Act (WHCRA)

Under the **Women’s Health and Cancer Rights Act of 1998**, all plans that cover mastectomies are also required to cover related reconstructive Surgery. Available reconstructive Surgery must include both reconstruction of the breast on which Surgery was performed and Surgery and reconstruction of the other breast to produce a symmetrical appearance. Coverage must also be available for breast prostheses and for the physical complications of a mastectomy, including lymphedema. These services are elective and are chosen by the patient in consultation with the attending Physician. They are subject to the usual Deductible, Coinsurance and Copayment provisions of the Plan.

Nondiscrimination In Health Care

In accordance with the Affordable Care Act, to the extent an item or service is a covered benefit under the Plan, and consistent with reasonable medical management techniques with respect to the frequency, method, treatment or setting for an item or service, the Plan will not discriminate with respect to participation under the Plan or coverage against any health care provider who is acting within the scope of that provider’s license or certification under applicable State law.

In this context, discrimination means treating a provider differently based solely on the type of the provider’s license or certification. The Plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the Plan.

The Plan is permitted to establish varying reimbursement rates based on quality or performance measures.

Patient Protection Rights Of The Affordable Care Act

The Anthem Medical PPO Plan in this document does not require the selection or designation of a primary care provider (PCP). You have the ability to visit any network or Non-Network health care provider; however, payment by the Plan may be less for the use of a Non-Network provider.

You also do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the medical network at their website listed on the Quick Reference Chart.

Information About Medicare Part D Prescription Drug Plans For Individuals With Medicare

If you and/or your Dependent(s) are entitled to Medicare Part A or enrolled in Medicare Part B, you are also eligible for Medicare Part D Prescription Drug Plan (PDP) benefits.

It has been determined that the Prescription Drug coverage of the Anthem Medical PPO Plan outlined in this document is “creditable.”

“Creditable” means that the value of this Plan’s Prescription Drug benefit is, on average for all Plan participants, expected to pay out as much as the standard Medicare Part D Prescription Drug Plan (PDP) coverage will pay.

Because this Plan’s Prescription Drug coverage is as good as Medicare, you do not need to enroll in a Medicare Part D Prescription Drug Plan (PDP) in order to avoid a late enrollment penalty under

Medicare. You may, in the future, enroll in a Medicare Part D Prescription Drug Plan (PDP) during Medicare's annual enrollment period (generally October 15th through December 7th of each year).

You can keep your current medical and Prescription Drug coverage with this Plan and you do not have to enroll in Medicare Part D. If, however, you keep this Plan coverage and also enroll in a Medicare Part D Prescription Drug Plan (PDP) you will have dual Prescription Drug coverage. Because outpatient Drugs are managed by a Pharmacy Benefit Manager, this Plan does not coordinate its outpatient Drug payments with Medicare. Outpatient Drugs are processed as if you do not have other coverage, including as if you do not have Medicare Drug coverage.

If you enroll in a Medicare Part D Prescription Drug Plan (PDP) you will need to pay the Medicare Part D premium out of your own pocket.

Note that you may not decline just the Prescription Drug coverage under this Plan. That is because Prescription Drug coverage is part of the entire Anthem Medical PPO Plan. Generally, you may only decline medical plan coverage at this Plan's next Open Enrollment period.

If you do not have creditable Prescription Drug coverage and you do not enroll in a Medicare Part D Prescription Drug Plan when first offered that enrollment opportunity, you may have a late enrollment fee on the premium you pay for Medicare coverage if and when you do enroll for Medicare Drug coverage.

Medicare-Eligible Individuals can enroll in a Medicare Part D Prescription Drug Plan at one of the following 3 times:

- when they first become eligible for Medicare; or
- during Medicare's annual election period (generally October 15th through December 7th); or
- for beneficiaries leaving employer/union-sponsored group health coverage, you may be eligible for a Special Enrollment Period in which to sign up for a Medicare Part D Prescription Drug Plan.

For more information about creditable coverage or Medicare Part D coverage see the Plan's Medicare Part D Notice of Creditable Coverage (a copy is available from the Administrative Office at their number located on the Quick Reference Chart in the front of this document. See also: www.medicare.gov for personalized help or call 1-800-MEDICARE (1-800-633-4227).

Coverage Of Certain Drugs Mandated By The Affordable Care Act (ACA)

For an over-the-counter or Prescription Drug listed below to be covered by the Plan, the Drug must be:

- a. obtained through the outpatient Prescription Drug Program at a participating network retail or mail order pharmacy and
- b. presented to the pharmacist with a prescription for the Drug from your Physician or Health Care Practitioner.

The following chart outlines the current OTC and Prescription Drugs that are payable by the Anthem Medical PPO Plan discussed in this document, in accordance with Affordable Care Act (ACA) regulations and the US Preventive Service Task Force (USPSTF) A and B recommendations, **and when prescribed, are payable at no charge when filled at a network pharmacy.**

Where the information in this document conflicts with newly released Affordable Care Act (ACA) regulations affecting the coverage of OTC and Prescription Drugs, this Plan will comply with the new requirements on the date required.

Drug Name	Who Is Covered for this Drug?	Your Cost-Sharing?	Payment Parameters for Prescribed Drugs
FDA-approved Contraceptives for females, such as birth control pills, spermicidal products and sponges	All females	None, if payment parameters are met	<ul style="list-style-type: none"> Up to a month's supply of prescription contraceptives per purchase (or 3 month supply of certain 90-day dosed contraceptives like Seasonale) are payable under the Plan's Prescription Drug Program for females younger than 60 years of age. Generic FDA approved contraceptives are at no cost to the Plan participant when obtained from a network provider. Brand contraceptives are payable only if a generic alternative is medically inappropriate or unavailable.
Breast cancer preventive medication	Women who are at increased risk for breast cancer and at low risk for adverse medication effects.	None, if payment parameters are met	Plan covers generic breast cancer preventive Drugs such as tamoxifen or raloxifene.
Aspirin	<ul style="list-style-type: none"> For pregnant women who are at high risk for preeclampsia (a pregnancy complication). Low-dose aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% or greater 10-year cardiovascular risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years. 	None, if payment parameters are met	<ul style="list-style-type: none"> For non-pregnant adults: since dosage is not established by USPSTF, Plan covers up to one bottle of generic 100 tablets every 3 months. Daily low-dose aspirin (81 mg) as preventive medication after 12 weeks' gestation in pregnant women who are at high risk for preeclampsia. The use of aspirin is recommended when the potential benefit outweighs the potential harm due to an increase in gastrointestinal hemorrhage.
Folic acid supplements	All females planning or capable of pregnancy should take a daily folic acid supplement containing 0.4 – 0.8mg of folic acid	None, if payment parameters are met	Excludes women >55 years of age, and products containing more than 0.8mg or less than 0.4mg of folic acid. Plan covers generic folic acid up to one tablet per day.
Preparation "prep" Products for a Colon Cancer Screening Test	For individuals receiving a preventive colon cancer screening test.	None, if payment parameters are met	Plan covers the over-the-counter or prescription strength products prescribed by a Physician as preparation for a payable preventive colon cancer screening test, such as a colonoscopy for individuals age 50-75 years. Two fills per 365 days are covered.
Tobacco cessation products (FDA approved)	Individuals who use tobacco products.	None, if payment parameters are met	FDA-approved tobacco cessation Drugs (including both prescription and over-the-counter medications) are payable under the Plan's Prescription Drug Program, for up to two 90-day treatment regimens per year, which applies to all products. No preauthorization is required.

Drug Name	Who Is Covered for this Drug?	Your Cost-Sharing?	Payment Parameters for Prescribed Drugs
Fluoride supplements	For children starting at age 6 months when recommended by provider because the child's primary water source is deficient in fluoride.	None, if payment parameters are met	Plan covers generic versions of systemic dietary fluoride supplements (tablets, drops or lozenges) available only by prescription for children to age 6 years. Excludes products for individuals age 6 and older, topical fluoride products like toothpaste or mouthwash and excludes brand name fluoride supplements.
Statin preventive medication	Adults ages 40-75 years with: no history of cardiovascular disease (CVD), 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater.	None, if payment parameters are met	For adults <u>without</u> a history of cardiovascular disease (CVD) (i.e., symptomatic coronary artery disease or ischemic stroke), the Plan covers a <u>low- to moderate-dose statin</u> for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening (a lab test) in adults ages 40 to 75 years.

<p>What Is Covered And Described In The Schedule Of Medical Benefits</p>

Covered services and supplies for the Anthem Medical PPO Plan are described in the Schedule of Medical Benefits in Chapter 5.

Services and supplies are covered only if they are certified by the attending Physician and determined by the Plan to be Medically Necessary, except as specifically provided otherwise. Further, only Allowable Charges for covered services and supplies are considered when determining benefits under the Anthem Medical PPO Plan. Refer to the Glossary Chapter for the definition of Allowable Charges.

NOTE: Preauthorization is required for certain services to avoid non-payment of the claim. See the “Preauthorization” section earlier in this Chapter.

A schedule of the Anthem Medical PPO Plan benefits appears in Chapter 5, in a chart format. Each of the Plan’s Medical Benefits is described in the first column. Explanations and limitations that apply to each of the benefits are shown in the second column. Specific differences in the benefits when they are provided In-Network (when you use PPO Network Providers) and Out-of-Network (when you use Non-PPO, Non-Network Providers) are shown in the subsequent columns.

In the Schedule of Medical Benefits Deductibles, Out-of-Pocket Limits, Hospital Services (Inpatient) and Physician and Health Care Practitioner Services **are listed in the first few rows** because these categories of benefits apply to most (but not all) health care services covered by the Plan. These rows are followed by descriptions, **appearing in alphabetical order**, of the other covered medical benefits along with any limitations and exclusions to those covered benefits.

All benefits shown in the Schedule of Medical Benefits are subject to the Plan’s Deductibles unless there is a specific statement that the Deductible does not apply.

To determine the extent to which limitations apply to the benefits that are payable for any health care services or supplies you receive, you should also check to see if those services are listed separately in the Schedule of Medical Benefits, even if they seem to be included in Hospital Services or Physician and Health Care Practitioner Services, and you should also check the Exclusions Chapter 6 of this document to see if they are excluded.

The Glossary Chapter is available to help you understand many of the terms used in this document.

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE ANTHEM MEDICAL PPO PLAN

This chart explains the benefits payable by the Plan. See also the Exclusions and Glossary Chapters of this document for important information. All benefits are subject to the Deductible except where noted. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Glossary Chapter, and could result in Balance Billing to you.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of- Network
<p><u>Deductible</u></p> <ul style="list-style-type: none"> The annual Deductible is the amount of money you must pay each Calendar Year before the Plan begins to pay benefits. Deductibles are applied to the Eligible Medical Expenses in the order in which claims are processed by the Plan. Only Eligible Medical Expenses can be used to satisfy the Plan's Deductibles. The Deductible applies to all covered services except where otherwise noted in this Schedule of Medical Benefits. 	<ul style="list-style-type: none"> There is an annual Deductible when using network providers and a separate annual Deductible when using non-network providers. Note that the Network and Out-of-Network Deductibles are not interchangeable, meaning that you may not use a portion of a network Deductible to meet an out-of-network Deductible and vice versa. The family Deductible can be met by any combination of amounts from any family member. See also the section on Deductibles in Chapter 4 for information on the Deductible carryover provision and common accident provision. The Deductible does not apply to certain services noted in this Schedule, such as the Deductible does not apply to Preventive Care received from an in-network provider, ambulance services, or outpatient Prescription Drugs. 	<p>\$300 per person</p> <p>\$900 per family</p>	<p>\$500 per person</p> <p>\$1,500 per family</p>
<p><u>Out-of-Pocket Limit (Annual)</u></p> <p>The Out-of-Pocket Limit is the most you pay during a one-year period (the Calendar Year) before your medical plan starts to pay 100% for covered Essential Health Benefits received from Network providers.</p> <ul style="list-style-type: none"> Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan. There is no Out-of-Pocket Limit on the use of Out-of-Network providers, except that Emergency Services performed in an Out-of-Network Emergency Room will accumulate to meet the Network Out-of-Pocket Limit. The family Out-of-Pocket Limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than this Plan's "per person in a family" annual Out-of-Pocket Limit. Covered outpatient Prescription Drug expenses accumulate to a separate annual outpatient Drug Out-of-Pocket limit. 	<ul style="list-style-type: none"> The Anthem Medical PPO Plan Out-of-Pocket Limit does not include or accumulate: <ol style="list-style-type: none"> All services and supplies provided by Non-PPO (out-of-network) providers, except in cases involving Emergency Services performed in an Out-of-Network Emergency Room which do accumulate to the In-network Out-of-Pocket Limit Expenses that are not considered to be Essential Health Benefits, such as Spinal Manipulation/Chiropractic treatment Premiums and/or self-payment contributions for coverage Amounts you pay for non-covered services Charges above what the Plan allows (above the Allowable Charge) Charges in excess of the Anthem Medical PPO Plan's maximum benefits Dental Plan or Vision Plan expenses Any cost-sharing under the Outpatient Prescription Drug Benefit does not apply to the Anthem Medical PPO Plan Out-of-Pocket Limit but does apply to meet the separate annual outpatient Prescription Drug Out-of-Pocket Limit. The Anthem Medical PPO Plan Out-of-Pocket Limit does not include/accumulate outpatient Prescription Drug benefits while the Outpatient Prescription Drug Out-of-Pocket Limit does not include/accumulate other Medical plan benefits. The Outpatient Prescription Drug Out-of-Pocket Limit does not accumulate Drug costs related to amounts you pay for Prescription Drugs obtained at walk-in retail pharmacies after the second fill of a maintenance Drug. 	<p>Medical Plan: \$2,500 per person</p> <p>\$5,000 per family</p> <p>Outpatient Prescription Drugs: \$1,000 per person</p> <p>\$2,000 per family</p>	<p>No Out-of-Pocket Limit for use of out-of-network providers.</p> <p>Exception: Emergency Services performed in an Emergency room (ER) will accumulate to the In-network Out-of-Pocket Limit.</p>

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE ANTHEM MEDICAL PPO PLAN

This chart explains the benefits payable by the Plan. See also the Exclusions and Glossary Chapters of this document for important information. All benefits are subject to the Deductible except where noted. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Glossary Chapter, and could result in Balance Billing to you.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of- Network
<p><u>Hospital Services (Inpatient)</u></p> <ul style="list-style-type: none"> • Room & board facility fees in a semiprivate room with general nursing services. • Specialty care units within the Hospital (e.g., intensive care unit, cardiac care unit). • Lab/x-ray/diagnostic services. • Related Medically Necessary ancillary services (e.g., prescriptions, supplies). • Newborn care including newborn circumcision. See also the Maternity services row in this Schedule. 	<ul style="list-style-type: none"> • Preauthorization is required for elective Hospital admissions and for anesthesia services in connection with dental care, by calling the Preauthorization Program, whose contact information is listed on the Quick Reference Chart in the front of this document. See Chapter 4 for details. • Under certain circumstances the medical plan will pay for the facility fees and anesthesia associated with Medically Necessary dental services covered by a Dental Plan if the Anthem Medical PPO Plan Claims Administrator determines that hospitalization or outpatient Surgery facility care is Medically Necessary to safeguard the health of the patient during performance of dental services. The Anthem Medical PPO Plan does not cover the dental professional fees or dental products/supplies for the dental service that occurs at a Hospital or outpatient Surgery facility. • See the Eligibility Chapter for how to properly enroll Newborns so coverage can be considered. • Specialty care Hospitals, also called long term acute care (LTAC) Hospitals, are discussed under the Skilled Nursing Facility row in this Schedule. • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in a Hospital/health care facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters. • Hospital Outpatient Department in an Out-of-Network Hospital: After Deductible met, Plan pays 50% up to a Plan payment of \$3,500 for outpatient department services and supplies per episode of treatment. • Benefits will not be paid for any day in which the patient is released from the Hospital on a temporary pass. 	<p>After Deductible met, Plan pays 90%</p>	<p>After Deductible met, Plan pays 50%.</p>

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE ANTHEM MEDICAL PPO PLAN

This chart explains the benefits payable by the Plan. See also the Exclusions and Glossary Chapters of this document for important information. All benefits are subject to the Deductible except where noted. *IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Glossary Chapter, and could result in Balance Billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of-Network
<p><u>Physician and Other Health Care Practitioner Services</u></p> <ul style="list-style-type: none"> Benefits are payable for professional fees when provided by a Physician or other covered Health Care Practitioner in an office, Hospital, urgent care facility, Emergency room, outpatient/ambulatory Surgery center or other covered health care facility location. This benefit covers routine Hospital visits by Physicians for newborn care. Payable Physicians and Health Care Practitioner professional fees include: <ul style="list-style-type: none"> Surgeon Assistant surgeon (if Medically Necessary) Anesthesia provided by a Physician or Certified Registered Nurse Anesthetist (CRNA) Hospitalist, Pathologist, Radiologist, Podiatrist (DPM), Physician Assistant, Nurse Practitioner, Certified Nurse Midwife, paramedic, licensed perfusionist. Telemedicine services (online visit with a health care professional via video live chat) are payable. (see also the Quick Reference Chart for more information). See also the Family Planning, Maternity and Wellness rows where certain women's Preventive Services are payable without cost-sharing when obtained from Network providers. See also the Emergency Services row for payment of providers in an Emergency room. 	<ul style="list-style-type: none"> Preauthorization is required for anesthesia services in connection with dental care, Cosmetic procedures, transplant related services, referral to an out-of-network provider or facility and other services listed in Chapter 4, by calling the Preauthorization Program whose contact information is listed on the Quick Reference Chart in the front of this document. See also the definition of Physician, Health Care Practitioner and Surgery in the Glossary Chapter. The Plan Administrator or its Delegate will determine if multiple surgical or other medical procedures will be covered as separate procedures or as a single procedure based on the factors in the definition of "Surgery" in the Glossary Chapter. Assistant Surgeon fees will be reimbursed only for Medically Necessary services to a maximum of 20% of the eligible expenses allowed for the primary surgeon; however, the maximum is 10% of the Allowable Charge for the primary surgeon for the services of a state licensed Registered Nurse first assistant or state licensed Physician assistant. Under this Plan, there is no requirement to select a primary care Physician (PCP) or to obtain a referral or prior authorization before visiting an OB/GYN provider. Provider Hospital Visits: Not more than one visit to or by the same Physician is covered per day unless the patient is confined as a registered bed patient in a Hospital or Extended Care Facility. For purposes of this limitation, multiple office visits are considered to have occurred in a single day if the Physician bills more than one office visit charge for the same date of service and regardless of whether or not the patient had a return trip to the Physician's office. Newborn circumcision is payable. An office visit for a second or third opinion is payable. Generally there is no coverage for eye refraction, eyeglasses, contact lenses, or the fitting of eyeglasses or contact lenses; however see the Corrective Appliance row in this Schedule for more details. Surgical correction of refractive errors in vision is not covered, including but not limited to LASIK or similar procedures, except surgical correction is payable when the patient's vision cannot be corrected to 20/40 or better by eyeglasses or contact lenses (coverage is payable for one Surgery for each eye during a person's lifetime, up to a maximum Plan payment of \$1,000 for each Surgery). No coverage for acupuncture. Routine Foot Care is not covered; however, foot care is payable when Medically Necessary for individuals with diabetes or a neurological or vascular insufficiency affecting the feet. 	<p>Online visit with a health care professional via video live chat: You pay \$5.00/visit, Deductible does not apply.</p> <p>All other services: After Deductible met, Plan pays 90%.</p>	<p>After Deductible met, Plan pays 50%.</p>
<p><u>Allergy Services</u></p> <ul style="list-style-type: none"> Allergy sensitivity testing, including skin patch or blood tests such as Rast or Mast. Desensitization and hyposensitization (allergy shots given at periodic intervals). Allergy antigen solution. 	<ul style="list-style-type: none"> Allergy services are covered only when ordered by a Physician. 	<p>Testing, Allergy Shots, Allergy Antigen: After Deductible met, Plan pays 90%.</p>	<p>Testing, Allergy Shots, Allergy Antigen: After Deductible met, Plan pays 50%.</p>

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This chart explains the benefits payable by the Plan. See also the Exclusions and Glossary Chapters of this document for important information. All benefits are subject to the Deductible except where noted. *IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Glossary Chapter, and could result in Balance Billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of- Network
<p><u>Ambulance Services for Medical Emergency</u></p> <ul style="list-style-type: none"> • Ground vehicle Emergency transportation: <ul style="list-style-type: none"> • to the nearest appropriate facility as Medically Necessary for treatment of a medical Emergency or acute illness/injury; • for Medically Necessary inter-health care facility transfer (e.g. transfer from one Hospital to another Hospital or trip to and from one Hospital to another in order to obtain a special test/procedure). • Air/sea Emergency transportation is payable: (1) only when Medically Necessary for treatment of a life-threatening Emergency, and (2) the air/sea transport is required because of inaccessibility by ground transport and/or the use of ground transport would endanger the patient's health status. When air/sea ambulance transportation is required, it is payable to the nearest acute health care facility qualified to treat the patient's Emergency condition. • Medically necessary Non-Emergency medical transportation. 	<ul style="list-style-type: none"> • Expenses for ambulance services are covered only when those services are for an Emergency, as that term is defined in the Glossary Chapter of this document under the heading of "Emergency Care," or for Medically Necessary inter-health care facility transport. • Non-Emergency medical transportation refers to transport of an individual in a vehicle because the individual cannot safely use public or private transportation due to their Medically Necessary requirement to be positioned in a wheelchair or stretcher, or because they require the use of medical equipment or non-Emergency medical monitoring during transport. Non-Emergency medical transportation is not covered if used for convenience of the patient or their family. <u>Preauthorization is required for Non-Emergency medical transportation services</u>, by calling the Preauthorization Program, whose contact information is listed on the Quick Reference Chart in the front of this document. See Chapter 4 for details. When preapproved, the Plan may pay toward the least expensive and appropriate method of transportation that meets the physical and medical circumstances of the individual and the Plan reserves the right to limit its payment of transportation to the nearest appropriate location (such as the nearest provider of medical services when it has made a determination that traveling further distances provides no medical benefit to the individual). 	<p>Emergency Transport: You pay a \$50 Copay per trip, Deductible does not apply.</p>	<p>Emergency Transport: You pay a \$50 Copay per trip, Deductible does not apply.</p> <p>(Maximum Allowable Charge is up to \$50,000 per trip for an air ambulance and up to \$1,075 per trip for a ground ambulance.)</p>
<p><u>Ambulatory Surgical Center</u></p>	<ul style="list-style-type: none"> • See the Outpatient (Ambulatory) Surgery Facility row in this Schedule. 		

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE ANTHEM MEDICAL PPO PLAN

This chart explains the benefits payable by the Plan. See also the Exclusions and Glossary Chapters of this document for important information. All benefits are subject to the Deductible except where noted. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Glossary Chapter, and could result in Balance Billing to you.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of-Network
<p><u>Behavioral Health Services</u> (Mental Health and Substance Abuse Treatment)</p> <ul style="list-style-type: none"> Outpatient visits: including necessary Psychological (Psychiatric) Testing. Other Outpatient Services: partial day care/partial hospitalization or intensive outpatient program (IOP) care. See the Glossary Chapter for the meaning of the term partial day care. Inpatient acute Hospital admission, or Residential Treatment Program. See the Glossary Chapter for the meaning of the term residential treatment. Screening for tobacco use; and, for those who use tobacco products, the Plan covers at least two tobacco cessation attempts per year. Cessation support described to the right. The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in a Hospital/health care facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters. 	<ul style="list-style-type: none"> Preauthorization is required for elective Hospital admissions in connection with Mental Health and/or Substance Abuse treatment by calling the Preauthorization Program, whose contact information is listed on the Quick Reference Chart in the front of this document. See Chapter 4 for details. Benefits will not be paid for any day in which the patient is released from the Hospital on a temporary pass. For assistance locating Behavioral Health providers best qualified to treat your needs please contact the telephone number on your ID card. Behavioral Health Residential Treatment Program is covered for individuals needing treatment in a highly structured 24-hour therapeutic environment when care cannot be safely or effectively treated in a less intensive setting. A Residential Treatment Facility must be properly licensed in the state in which the facility operates. Outpatient Prescription Drugs for Behavioral Health payable under Drugs in this Schedule of Medical Benefits. Programs based on learning theories and motivation, such as Applied Behavior Analysis (ABA) Therapy, are a covered benefit. Tobacco Cessation support: The Plan covers, at no cost for Network providers, at least two tobacco cessation attempts per person per year. <ul style="list-style-type: none"> A cessation attempt includes coverage for four (4) tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and/or individual counseling with a licensed counselor, without preauthorization requirements). All FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) are covered at no cost from Network retail pharmacy locations for a 90-day treatment regimen when prescribed by Physician or Health Care Practitioner (without preauthorization). See also the Drug chart on page 62 and the Drug row in this Schedule. No coverage for marriage or family counseling, vocational rehabilitation, or any Hospital days on which the patient is released on a pass. See also the Exclusions Chapter 6. Benefits are payable for a maximum 8 hours per disability for psychometric testing and 4 visits per disability for biofeedback services. 	<p>Outpatient visits, Other Outpatient Services, Inpatient Hospital and Residential Treatment Program: After Deductible met Plan pays 90%.</p> <p>Tobacco Cessation Counseling: No charge. Deductible does not apply.</p>	<p>Outpatient visits, Other Outpatient Services, Inpatient Hospital and Residential Treatment Program: After Deductible met Plan pays 50%.</p> <p>Tobacco Cessation Counseling: Not covered.</p>
<p><u>Birthing Center/Facility</u></p>	<ul style="list-style-type: none"> See the Maternity Services row of this Schedule. 		
<p><u>Blood Transfusions</u></p> <ul style="list-style-type: none"> Blood transfusions and blood products and equipment for its administration. 	<ul style="list-style-type: none"> Covered only when ordered by a Physician. 	<p>After Deductible met, Plan pays 90%.</p>	<p>After Deductible met, Plan pays 50%.</p>
<p><u>Chemotherapy</u></p> <ul style="list-style-type: none"> Chemotherapy Drugs and supplies administered under the direction of a Physician in a Hospital, Health Care Facility, Physician's office or at home. 	<ul style="list-style-type: none"> Benefit payments may vary depending on the location in which the chemotherapy is delivered or received by the patient. For example, if chemotherapy is delivered in a Hospital, the Hospital Services coverage applies; if it is delivered at home or in a Physician's office, see Physician's and Other Health Care Practitioners row (above) in this Schedule of Medical Benefits. 	<p>Payment may vary according to the location in which the service is provided.</p>	<p>Payment may vary according to the location in which the service is provided.</p>

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE ANTHEM MEDICAL PPO PLAN

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of-Network
<u>Chiropractic Services</u>	<ul style="list-style-type: none"> See the Spinal Manipulation section of this Schedule of Medical Benefits. 		
<u>Circumcision</u> <ul style="list-style-type: none"> Circumcision for newborn males, birth through 2 years of age. 		After Deductible met, Plan pays 90%.	After Deductible met, Plan pays 50%.
<u>Corrective Appliances (Prosthetic & Orthotic Devices, other than Dental)</u> <ul style="list-style-type: none"> Coverage is provided for Medically Necessary Prosthetic and Orthotic devices as follows: <ul style="list-style-type: none"> rental (but only up to the allowed purchase price of the device). purchase of standard model. Rental or purchase determined by the Plan Administrator or its Delegate. repair, adjustment or servicing of the device when Medically Necessary. replacement of the device is payable if there is a change in the covered person's physical condition making the current device inoperable or unsatisfactory in order to perform normal daily activities (as certified by the patient's Physician), or if the device cannot be satisfactorily repaired. Corrective Appliances are covered only when ordered by a Physician or Health Care Practitioner. For hearing services see the Hearing Services row in this Schedule. 	<ul style="list-style-type: none"> See the exclusions related to Corrective Appliances in the Exclusions Chapter 6. To help determine what Prosthetic or Orthotic Appliances are covered, see the definitions of "Prosthetics" and "Orthotics" in the Glossary Chapter. Plan covers Prosthetic devices like artificial limbs or eyes. Replacement of a Prosthetic device is covered for a Dependent child when Medically Necessary as a result of the child's growth. Orthotics (non-foot): such as a cast, splint, brace such as a back brace or knee brace, are payable when Medically Necessary. A custom-made Orthotic device is payable where there is a failure, contraindication, or intolerance to an unmodified, prefabricated (off-the-shelf) Orthotic device. Foot Orthotics (orthopedic or corrective shoes and other supportive appliances for the feet) are payable (one pair every 12 months for adults). One pair of foot Orthotics payable once in a period of 6 months for children under age 19 when replacement is required due to growth. The Plan covers a single wig, toupee or hairpiece per person per lifetime. One eye examination and one pair of Medically Necessary eyeglasses or contact lenses are payable after the surgical removal of the lens of the eye, such as with a cataract extraction. 	After Deductible met, Plan pays 90%.	After Deductible met, Plan pays 50%.
<u>Diabetes Education</u>	<ul style="list-style-type: none"> Coverage is payable for diabetes education. 	After Deductible met, Plan pays 90%.	After Deductible met, Plan pays 50%.

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE ANTHEM MEDICAL PPO PLAN

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of- Network
<p><u>Dialysis</u></p> <ul style="list-style-type: none"> Dialysis for the treatment of acute kidney failure, end-stage kidney disease and chronic kidney disease. Hemodialysis or peritoneal dialysis and supplies administered under the direction of a Physician in a Hospital, Health Care Facility, Physician's office or at home. If you are eligible for Medicare but do not reenroll in both Medicare Part A and Part B after the 30-month coordination period is completed, this Plan will pay benefits <u>as if you have enrolled</u>. After the 30-month coordination period is completed, your claims will be reduced as secondary under this Plan regardless of your enrollment status under Medicare. <u>As a result, in order to receive the maximum amount of coverage to which you may be entitled under Medicare, you should consider enrolling in and paying any premiums required for Medicare coverage, including Part B, no later than the end of the 30-month coordination period.</u> 	<ul style="list-style-type: none"> Benefit payments may vary depending on the location in which the hemodialysis or peritoneal dialysis is performed or received by the patient. When you have reached the end stage of kidney failure (renal impairment) that causes your Physician to recommend a kidney transplant or regular course of dialysis, you may be eligible for Medicare. It is important that individuals with end stage renal disease (ESRD) promptly apply for Medicare coverage, regardless of age. If you qualify for Medicare Part A (coverage for Hospitals), you can also get Medicare Part B (coverage for outpatient services, ambulance, DME). Enrolling in Part B is your choice, but you'll need both Medicare Part A and Part B to get the full benefits available under Medicare to cover certain dialysis and kidney transplant services. See also the Coordination of Benefits Chapter 9 that discusses what this Plan pays when you are also Medicare eligible. Medicare and ESRD: Once you are eligible for Medicare, you should apply for enrollment in Medicare. If the application for enrollment is accepted, Medicare coverage may begin. Medicare coverage begins at different times for different people depending on the circumstances. Medicare coverage usually starts the first day of the 3rd month after the month in which a course of regular dialysis begins. All, or a portion of, the 3-month waiting period may be waived if you participate in a self-dialysis training program, or if you have a kidney transplant within the 3-month waiting period. <p>When you are on dialysis and covered by both Medicare and this group health plan, for the first 30 months (referred to a 30-month coordination period), your group health plan is the primary payer of your dialysis and other covered medical services. It is important to note that the 30-month coordination period always begins on the date you are first eligible to enroll in Medicare due to ESRD. If for example, you fail to submit a timely application for Medicare or choose not to apply for Medicare, the 30-month coordination period will be calculated with a start date based on the month in which you could have been enrolled, had you made an application for Medicare.</p> <p>Medicare becomes the primary payer of benefits after the 30-month coordination period ends, as long as you retain Medicare eligibility based on ESRD. A Medicare beneficiary may have more than one 30-month coordination period. Medicare entitlement (meaning eligibility and coverage under Medicare) because of ESRD, will end if you have not received dialysis for 12 months, or if 36 months have passed since you had a successful kidney transplant.</p>	<p>Payment may vary according to the location in which the service is provided.</p>	<p>Payment may vary according to the location in which the service is provided.</p>
<p><u>Dietitian Services</u></p> <ul style="list-style-type: none"> See also the Diabetes Education row in this Schedule. 	<ul style="list-style-type: none"> Certain dietary counseling may be payable as a Wellness service in accordance with requirements of the Affordable Care Act (ACA). As a preventive counseling benefit in compliance with the Affordable Care Act (ACA), the Plan covers the following services: For adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention. 	<p>Preventive Counseling Benefit: 100% no Deductible</p>	<p>Preventive Counseling Benefit: 100% no Deductible</p>

Drugs (Outpatient Medicines)

- Coverage is provided for those pharmaceuticals (drugs and medicines) approved by the US Food and Drug Administration (FDA) as requiring a prescription and are FDA approved for the condition, dose, route, duration and frequency, if prescribed by a Physician or other Health Care Practitioner authorized by law to prescribe them.
- Contact the Prescription Benefit Manager (PBM) (whose phone number is listed on the Quick Reference Chart in the front of this document) for the following:
 - The Drugs on the **National Preferred Formulary**.
 - Information on **Drugs requiring preauthorization** (pre-approval) by the clinical staff of the Prescription Benefit Manager (PBM), such as growth hormones, interferon, controlled substance for pain treatment, Retin-A over age 25, hepatitis C Drugs, Botox, certain brand name Drugs and testosterone replacement.
 - Information on which **Drugs have a limit to the quantity** payable by this Plan, such as sleeping pills.
 - Information on which Drugs are part of the **step therapy program** where you first try a proven, cost-effective medication before moving to a more costly Drug option.
 - **Specialty Drugs** are available on an outpatient basis when ordered through and managed by the Prescription Benefit Manager (PBM). Specialty Drugs are generally considered high-cost injectable, infused, oral or inhaled products that require close supervision and monitoring and are used by individuals with unique or chronic conditions such as multiple sclerosis, rheumatoid arthritis, Crohn's disease, psoriasis, cancer or hepatitis. These Drugs **need prior authorization**, often require special handling, are date sensitive and are generally available only in a 30-day quantity.
- Covered outpatient Prescription Drugs do accumulate to meet an **annual Drug Out-of-Pocket Limit** but does not include amounts you pay for Prescription Drugs obtained at walk-in retail pharmacies after the second fill of a maintenance Drug.
- Drugs not yet FDA-approved are not covered. **New FDA-approved Drugs** will be covered unless an amendment states otherwise, or the class of Drug is excluded.

The Prescription Drug Program: Benefits for Prescription Drugs are provided through the Plan's Prescription Benefit Manager (PBM) whose name is listed on the Quick Reference Chart in the front of this document.

- **If the cost of the Drug is less than the Copay, you pay just the Drug cost.**
- **Retail Drugs:** To obtain up to a 30-day supply of medicine for the Copay noted to the right, present your ID card to any Network retail pharmacy. Contact the Prescription Benefit Manager (PBM) (whose name is listed on the Quick Reference Chart) for the location of Network retail pharmacies.
- **Note that after a maintenance Drug has been filled two times at a retail pharmacy, you are REQUIRED TO OBTAIN any future refill of that maintenance Drug through the Mail Order.**
- **Mail Order (Home Delivery) Drug Service:** The mail order service is the easiest and least expensive way to obtain many maintenance use Drugs, plus the medications are mailed directly to your home. You may use the mail order service (see the Quick Reference Chart) to receive up to a 90-day supply of non-Emergency, extended-use "maintenance" Prescription Drugs, such as for high blood pressure, high cholesterol, or diabetes. Note that not all medicines are available via mail order. Check with the Prescription Benefit Manager (PBM) for further information. To use the mail order service, have your doctor write the prescription for a 90-day supply, with the appropriate refills. Then, mail your prescription, Copay and the mail order form to the Mail Order Services of the Prescription Benefit Manager (PBM) whose address is listed on the Quick Reference Chart. Mail order forms may be obtained from the Prescription Benefit Manager (PBM). Allow up to 14 days to receive your order.
- **Direct Member Reimbursement for use of an Out-of-Network Retail Pharmacy:** If you fill a prescription at an Out-of-Network pharmacy location, you will need to pay for the Drug at the time of purchase and later (within 1 year), send your Drug receipt to the Prescription Benefit Manager (PBM) using the Direct Member Reimbursement (DMR) process. DMR forms may be obtained from the Prescription Benefit Manager (PBM). Be sure to send a copy of the pharmacy Drug receipt and sign the DMR claim form. For eligible prescriptions, the Plan reimburses 80% of what it would have paid had you used a network pharmacy and you pay a \$60 Copay plus 20% Coinsurance. Note: Specialty Drugs are not payable out-of-network, plus, foreign Drug claims and allergy Drug claims are not covered through direct member reimbursement.
- The Plan provides a **mandatory generic program** meaning that if a brand name Drug is dispensed in place of a generic Drug, regardless if you or your doctor request it, **you will pay the brand Copay plus the difference in cost** between the generic and brand name Drug (except when a generic Drug is unavailable or medically inappropriate, as determined by the attending provider).
- No coverage for male contraceptives, injectable forms of erectile dysfunction treatment, Cosmetic Drugs, anti-obesity Drugs, and fertility treatment Drugs. See also the exclusions related to Drugs (Medicines) in the Exclusions Chapter 6.
- In accordance with the Affordable Care Act (ACA), certain **over-the-counter (OTC) and Prescription Drugs** are payable at no charge when prescribed and filled at a network pharmacy. For details, see the Drug chart on page 62. For **FDA-approved contraceptives for females:** 100%, no cost-sharing for generic contraceptives. No charge for brand prescription contraceptives only if a generic contraceptive is unavailable or medically inappropriate as determined by the attending provider.
- Certain **CDC recommended vaccinations** are payable at 100%, no cost sharing when obtained at a network retail pharmacy. Contact the Prescription Drug Program for more information.
- Prescription Drug coverage under this Plan is considered to be creditable (as valuable as) Medicare Drug coverage.
- Non-sedating anti-histamine medication (e.g. Claritin, Zyrtec) are excluded; however, if the prescription is filled at a Participating Pharmacy, the Eligible Individual is only responsible for 100% of the contracted price for such medication.

No Deductible applies to outpatient Drugs.

Annual Calendar Year Out-of-Pocket Limit for outpatient Drugs is \$1,000/person; \$2,000/family.

Network Retail Pharmacy (up to a 30-day supply):

Generic: \$10 Copay.

Preferred (Formulary) Brand: \$40 Copay

Non-Preferred Brand: \$60 Copay

Specialty Drugs: \$50 Copay

ACA-mandated No Cost Drugs: FDA-approved female contraceptives, certain Drugs to reduce the risk of breast cancer, low dose statins, aspirin, tobacco cessation Drugs and certain over-the-counter Drugs.

Mail Order Service

(up to a 90-day supply):

Generic: \$25 Copay

Preferred (Formulary) Brand: \$100 Copay

Non-Preferred Brand: \$150 Copay

Specialty Drugs: \$100 Copay

Use of an Out-of-Network Retail Pharmacy:

If you fill a prescription at an Out-of-Network retail pharmacy location, you will need to pay for the Drug at the time of purchase and later, send your Drug receipt to the Prescription Benefit Manager (PBM) using the Direct Member Reimbursement (DMR) process as described to the left.

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE ANTHEM MEDICAL PPO PLAN

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of-Network
<p><u>Emergency Room Facility, Urgent Care Facility</u></p> <ul style="list-style-type: none"> Hospital Emergency room (ER) for “Emergency Services” (as that term is defined in this Plan). Urgent Care facility. Common medical conditions that may be appropriate for a Physician office or Urgent Care facility (instead of an Emergency Room) include, but are not limited to, fever, sore throat, earache, cough, flu symptoms, sprains, bone or joint injuries, diarrhea or vomiting, or bladder infections. Ancillary charges (such as lab or x-ray) performed during the ER or Urgent care visit. (See also the Ambulance section of this schedule.) The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in an Emergency room or urgent care facility are usually billed separately from the facility fee. Both the Emergency room visit facility and professional fees are payable as part of the Emergency room visit in this row. 	<ul style="list-style-type: none"> Expenses for Emergency Room services are covered only when those services are for an Emergency as that term is defined in the Glossary Chapter of this document under the heading of “Emergency Services.” Emergency room facility services are subject to a Copayment per visit. The Copayment will be waived if a subsequent immediate Hospitalization is required. There is no requirement to preauthorize the use of a Hospital-based Emergency room visit. The Plan will pay a reasonable amount for Hospital-based Emergency Services performed Out-of-Network, in compliance with Affordable Care Act (ACA) regulations. See the definition of Allowed Charge and Emergency Services. Contact the Anthem Medical PPO Plan Claims Administrator for details on what the Plan allows as payment to Out-of-Network Emergency Service providers. 	<p>Emergency Services in an Emergency Room: You pay a \$250 Copay per visit then Plan pays balance at 90% of the Allowed Charge after the Deductible is met.</p> <p>Urgent Care Facility: After Deductible met, Plan pays 90%.</p>	<p>Emergency Services in an Emergency Room: You pay a \$250 Copay per visit then Plan pays balance at 90% of the Allowed Charge after the Deductible is met.</p> <p>Non-Emergency Services in an Emergency Room: You pay a \$250 Copay per visit then Plan pays balance at 50% of the Allowed Charge after the Deductible is met.</p> <p>Urgent Care Facility: After Deductible met, Plan pays 90%.</p>

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of-Network
<u>Extended Care Facility</u>	<ul style="list-style-type: none"> See the Skilled Nursing Facility row in this Schedule. 		
<u>Family Planning, Reproductive, Contraceptive Fertility Services</u> <ul style="list-style-type: none"> Sterilization services (e.g., vasectomy, tubal ligation, implants). Coverage is provided for ACA mandated (Preventive Service) FDA-approved female contraceptives such as oral birth control pills/patch, Emergency contraception, injectables (e.g., Depo-Provera, Lunelle), intrauterine device (IUD) and removal of IUD, cervical cap, contraceptive ring (e.g. NuvaRing), diaphragm, implantable birth control device/service (e.g. Implanon, Nexplanon). See also the Drug row in this Schedule for information on FDA-approved contraceptive coverage where there is no charge for generic FDA-approved contraceptives submitted with a prescription and obtained from a network pharmacy location or from mail order. No charge for a brand prescription contraceptive only if a generic contraceptive is unavailable or medically inappropriate as determined by the Physician. No coverage for FDA approved contraceptives obtained from a Non-Network retail pharmacy. Fertility and infertility services include evaluation (diagnosis), only. Non-injectable treatment for male erectile dysfunction is covered. See the Drug row of this Schedule. 	<ul style="list-style-type: none"> For maternity coverage see the Maternity row in this schedule. No coverage for reversal of sterilization procedures. No coverage for the treatment of infertility. Certain contraceptives are payable under the row on Drugs (Medicines) coverage. In accordance with ACA, there is no cost-sharing for FDA-approved female contraceptives and female sterilization services and benefits will be paid at 100% no Deductible, in-network only. Certain contraceptives are available through the Prescription Drug Program (see the Drug row of this Schedule). No coverage for injectable forms of treatment for male erectile dysfunction (e.g., Caverject). See the specific exclusions related to Drugs, Medicines and Nutrition; Fertility and Infertility; Maternity Services; and Erectile Dysfunction Services in the Exclusions Chapter 6. 	<p>Female Contraceptives and Female sterilization procedures: 100%, no Deductible.</p> <p>For other services: After Deductible met, Plan pays 90%.</p>	<p>After Deductible met, Plan pays 50%.</p>

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of-Network
<p>Genetic Testing and Counseling</p> <ul style="list-style-type: none"> • Medically necessary Genetic Testing payable under this Plan is for: <ul style="list-style-type: none"> a) state-mandated newborn screening tests for genetic disorders; b) Genetic Testing (e.g. BRCA, stool DNA testing like Cologuard) and Genetic Counseling required as a Preventive service in accordance with the Affordable Care Act (ACA) regulations (see the Wellness row in this Schedule). c) fluid/tissue obtained as a result of amniocentesis, chorionic villus sampling (CVS), and alpha-fetoprotein (AFP) analysis in covered pregnant women and only if the procedure is Medically Necessary as determined by the Plan Administrator or its Delegate; d) tests to determine sensitivity to FDA approved Drugs, such as the Genetic Test for warfarin (blood thinning medication) sensitivity; e) Genetic Testing recommended by the American College of Obstetrics and Gynecology for pregnant women such as prenatal genetic screening for cystic fibrosis; f) the detection and evaluation of chromosomal abnormalities or genetically transmitted characteristics in covered participants if <u>all</u> the following conditions are met: <ul style="list-style-type: none"> • the testing method is considered scientifically valid for identification of a genetically-linked heritable disease; <u>and</u> • the covered individual displays clinical features/symptoms, or is at direct risk (family history or 1st or 2nd degree relative) of developing the genetically linked heritable disease/condition in question (pre-symptomatic); <u>and</u> • the results of the test will directly impact clinical decision-making; outcome or treatment being delivered to the covered individual. 	<ul style="list-style-type: none"> • Participants can contact the Medical Plan Claims Administrator for guidance on whether a proposed Genetic Test is a covered benefit. • Genetic Counseling is payable when ordered by a Physician, performed by a qualified Genetic Counselor (or other qualified health care provider) and provided with regard to a Genetic Test that is payable by this Plan. Certain Genetic Counseling is payable as a Preventive service in accordance with the Affordable Care Act (ACA) regulations. • See the definitions of Genetic Counseling, Genetic Testing in the Glossary Chapter. • See the Exclusions Chapter 6 for exclusions relating to Genetic Testing and Counseling, in addition to those indicated here. 	<p>Affordable Care Act (ACA) required Genetic Tests & counseling: 100% no Deductible.</p> <p>All other services: After Deductible met, Plan pays 90%.</p>	<p>After Deductible met, Plan pays 50%.</p>

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of- Network
<p><u>Hearing Services</u></p> <ul style="list-style-type: none"> An audiological evaluation to measure the extent of hearing loss and to determine the most appropriate make and model of hearing aid. An external hearing aid (monaural or binaural) is covered including the ear mold(s), the external hearing aid, batteries, cords and other ancillary equipment. The Plan covers visits for hearing aid fitting, counseling, adjustments, and repairs for the covered hearing aid. Implantable hearing device, such as a cochlear implant, is covered when Medically Necessary. 	<ul style="list-style-type: none"> Hearing (audiology) exam is payable like a Physician office visit. Coverage for a Medically Necessary external hearing aid is payable up to \$1,000 per hearing device, payable once each 24 months, when accompanied by a written recommendation from an otolaryngologist (Physician specializing in ear and throat disorders) or state-certified audiologist (provider trained to evaluate hearing loss and related disorders). No coverage for charges for a hearing aid which exceeds the device prescribed for the correction of hearing loss, or a hearing aid that is not Medically Necessary. 	<p>Audiology Exam: After Deductible met, Plan pays 90%.</p> <p>External Hearing Aid: After Deductible met, Plan pays 90%.</p> <p>Implantable hearing device: After Deductible met, Plan pays 90%.</p>	<p>Audiology Exam: After Deductible met, Plan pays 50%.</p> <p>External Hearing Aid: After Deductible met, Plan pays 90%.</p> <p>Implantable hearing device: After Deductible met, Plan pays 50%.</p>
<p><u>Home Health Care and Home Infusion Therapy Services</u></p> <ul style="list-style-type: none"> Part-time, intermittent Skilled Nursing Care services and Medically Necessary supplies to provide in-home Home Health Care or home infusion services. When a Registered Nurse or licensed vocational nurse provides services, benefits will be paid only for those services rendered by the nurse that require the skill and training of the nurse. These benefits do not cover services of a nurse's aide, Custodial Care or housekeeping services. 	<ul style="list-style-type: none"> Preauthorization of Home health care and Home Infusion therapy is required by calling the Preauthorization Program whose contact information is listed on the Quick Reference Chart in the front of this document. See also Chapter 4 for details. See the exclusions related to Home Health Care and Custodial Care (including personal care and child care) in the Exclusions Chapter 6 of this document. Home Hospice coverage is payable under Hospice benefits. Home Physical Therapy services coverage is payable under the Rehabilitation Services benefits. 	<p>After Deductible met, Plan pays 90%.</p>	<p>After Deductible met, Plan pays 50%.</p>

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE ANTHEM MEDICAL PPO PLAN

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of- Network
<p><u>Hospice</u></p> <ul style="list-style-type: none"> Hospice services (palliative care for terminally ill persons and likely to result in death within a 180-day/6 month period) include inpatient hospice care and outpatient home hospice care. The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in a hospice inpatient facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters. 	<ul style="list-style-type: none"> <u>Preauthorization of hospice services is required</u> by calling the Preauthorization Program whose contact information is listed on the Quick Reference Chart in the front of this document. See also Chapter 4 for details. Covered only when ordered by a Physician. Hospice benefits are payable for a period of up to 180 days per lifetime (whether or not there has been a disruption in coverage). Hospice care will not be paid if the hospice program is not certified by Medicare. 	Home hospice or Inpatient hospice: After Deductible met, Plan pays 90%.	Home hospice or Inpatient hospice: After Deductible met, Plan pays 90%.
<p><u>Laboratory Services (Outpatient)</u></p> <ul style="list-style-type: none"> Technical and professional fees. 	<ul style="list-style-type: none"> Covered only when ordered by a Physician or Health Care Practitioner. Inpatient Laboratory Services are covered under the Hospital Services section of this Schedule of Medical Benefits. Some laboratory services are payable under the Preventive (Wellness) benefits in this Schedule. 	After Deductible met, Plan pays 90%.	After Deductible met, Plan pays 50%.

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of-Network
<p>Maternity Services</p> <ul style="list-style-type: none"> Hospital and medical services and supplies in connection with the pregnancy of an Eligible Individual who is a female employee or Dependent Spouse are covered on the same basis as an illness. Plan covers Hospital and Birth (Birthing) Center charges and Physician and Certified Nurse Midwife fees for Medically Necessary maternity services. Coverage for the baby is only payable if the child is a Dependent Child as defined in this Plan, and properly enrolled in a timely manner. See the Eligibility Chapter on how to enroll a Newborn Dependent Child(ren). Breastfeeding equipment (breast pump) and supplies needed to operate the pump are payable as noted on the Durable Medical Equipment row of this Schedule. For females who are breastfeeding, the Plan pays for comprehensive lactation support and counseling (including breastfeeding classes) at 100%, no Deductible, when provided by a network provider acting within the scope of the provider's license. Network providers are listed on the network directory described on the Quick Reference Chart. Elective induced (voluntary) abortion. See Genetic Testing row for additional information. See the Family Planning row and Drug row for information on contraceptive coverage. 	<ul style="list-style-type: none"> The Plan does pay for Affordable Care Act (ACA) mandated expenses related to the maternity care associated with all females including a pregnant Dependent child, but the Plan DOES NOT pay for <u>ultrasounds and delivery expenses for pregnant Dependent children or for a pregnant Dependent child who has elected COBRA.</u> Certain prenatal care/maternity related Preventive Care expenses are payable for all females (as listed on the government websites at http://www.hrsa.gov/womensguidelines/ or https://www.healthcare.gov/what-are-my-preventive-care-benefits/ including but not limited to routine prenatal obstetrical office visits, screening for gestational diabetes, HPV testing starting at age 30, blood pressure screening throughout a pregnancy to check for preeclampsia, and when breastfeeding there is coverage for breastfeeding equipment and supplies need to operate the equipment and comprehensive lactation support and counseling). These services are covered without cost sharing for a female when obtained from Network providers. Hospital Length of Stay for Childbirth: Under federal law, group health plans, like this Plan, generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., Physician, or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans may not set the level of benefits or Out-of-Pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. If you deliver in the Hospital, the 48-hour period (or 96-hour period) starts at the time of delivery. In addition, the Plan may not, under federal law, require that a Physician or other Health Care Practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your Out-of-Pocket costs, you may be required to obtain preauthorization. For information on <u>preauthorization for a length of stay longer than 48 hours for vaginal delivery or 96 hours for C-section delivery</u>, contact the Preauthorization Program to preauthorize the extended Hospital stay. Refer to Chapter 4 for information on preauthorization. You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. Elective induced (voluntary) abortion is covered only for the covered employee or covered Spouse. 	<p>Prenatal and postnatal office visits and ACA-mandated Preventive Services: No charge, Deductible does not apply.</p> <p>Lactation counseling and breast-feeding equipment and supplies: No charge, Deductible does not apply.</p> <p>For Delivery fees: refer to Physician and Hospital rows of this schedule.</p>	<p>After Deductible met, Plan pays 50%.</p>

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of- Network
<p><u>Mental Health and Substance Abuse/Substance Use Disorder Treatment</u></p>	<ul style="list-style-type: none"> See the Behavioral Health row of this Schedule. 		
<p><u>Nondurable Medical Supplies</u></p> <ul style="list-style-type: none"> Coverage is provided for Medically Necessary Nondurable Supplies dispensed and used by a Physician or Health Care Practitioner in conjunction with treatment of the covered individual. Coverage is provided for Medically Necessary home/personal use: <ul style="list-style-type: none"> Sterile surgical supplies used immediately after surgery. Supplies needed to operate or use covered Durable Medical Equipment or Corrective Appliances. Supplies needed for use by skilled home health or home infusion personnel, but only during the course of their required services. Dialysis supplies. Colostomy and ostomy supplies and/or urinary catheter supplies. Diabetic supplies (e.g., insulin syringes, test strips, lancets) are covered under the Prescription Drug Program. Necessary diabetic insulin pump supplies (if not available under the Prescription Drug Program) are payable under this benefit. 	<ul style="list-style-type: none"> To determine what Nondurable Medical Supplies are covered, see the definition of “Nondurable Supplies” in the Glossary Chapter. 	<p>After Deductible met, Plan pays 90%.</p>	<p>After Deductible met, Plan pays 50%.</p>
<p><u>Nutritional Supplemental Infusions</u></p> <ul style="list-style-type: none"> Nutritional supplemental infusions (such as tube feedings to sustain life) are payable, based on the patient’s diagnosis and medical condition, when required to sustain life or maintain a reasonable level of good health as determined by the Claims Administrator. 	<ul style="list-style-type: none"> <u>Preauthorization is required for Home infusion therapy</u>, by calling the Preauthorization Program whose contact information is listed on the Quick Reference Chart in the front of this document. See also Chapter 4 for details. 	<p>After Deductible met, Plan pays 90%.</p>	<p>After Deductible met, Plan pays 50%.</p>

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of- Network
<p><u>Oral and Craniofacial Services</u></p> <ul style="list-style-type: none"> • Medically Necessary maxillofacial surgical procedures are covered when performed by a Physician (M.D.) or qualified oral and/or maxillofacial surgeon. • Accidental Injury to Teeth/Jaw. • Oral and/or Craniofacial Surgery. • Charges by an oral maxillofacial surgeon for reduction of facial bone fractures, removal of jaw tumors, treatment of jaw dislocations, treatment of facial and oral wounds or lacerations or infections (cellulitis), and removal of cysts or tumors of the jaws/facial bones. See also the exclusions related to Dental Services in the Exclusions Chapter 6. 	<ul style="list-style-type: none"> • Treatment of Accidental Injuries to the Teeth: This medical plan will pay for treatment of certain accidental injuries to the teeth and jaws when, in the opinion of the Plan Administrator or its Delegate, all of the following conditions are met: <ol style="list-style-type: none"> a) The accidental injury must have been caused by an extrinsic/external force and not an intrinsic force (such as the force of chewing or biting); and b) The dental treatment to be payable is the most cost-effective option that meets acceptable standards of professional dental practice; and c) The dental treatment will return the person's teeth to their pre-injury level of health and function. The dental treatment provider is encouraged to seek pre-treatment approval from the Plan Administrator for dental work. <p>Injury to Teeth means an injury to the teeth caused by trauma from an external source, and does not include an injury to the teeth caused by any intrinsic force, such as the force of biting or chewing.</p> • Oral or craniofacial surgery is covered for certain Medically Necessary reconstructive purposes, but not for Cosmetic purposes. • No coverage for treatment or Surgery related to Temporomandibular Joint (TMJ/TMD) dysfunction or syndrome. Other than the services noted as covered in this row, the Plan does not cover other dental services, including but not limited to removal of teeth including removal of wisdom teeth, endodontics such as root canal, gingivectomy, procedures in preparation for future dental work or dental implant (such as sinus lift, soft tissue graft, bone graft/replacement), treatment or prevention of Temporomandibular Joint dysfunction/syndrome, or orthognathic Surgery for treatment of aesthetic malposition of the bones of the jaw. See also the exclusions related to Dental Services in the Exclusions Chapter 6. 	<p>Physician services payable according to the Physician services row of this Schedule.</p>	<p>Physician services payable according to the Physician services row of this Schedule.</p>
<p><u>Osteopathic Manipulation</u></p>	<ul style="list-style-type: none"> • See the Spinal Manipulation row in this Schedule. 		

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of- Network
<p><u>Outpatient (Ambulatory) Surgery Facility/Center</u></p> <ul style="list-style-type: none"> Ambulatory (Outpatient) Surgical Facility/Center (e.g. ambulatory center, surgicenter, same day Surgery, outpatient Surgery). The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in an outpatient (Ambulatory) Surgery facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters. 	<ul style="list-style-type: none"> Under certain circumstances the Anthem Medical PPO Plan will pay for the facility fees and anesthesia associated with Medically Necessary dental services covered by a Dental Plan if the Anthem Medical PPO Plan Claims Administrator determines that Hospitalization or outpatient Surgery facility care is Medically Necessary to safeguard the health of the patient during performance of dental services. The medical plan does not cover the dental professional fees or dental products/supplies for the dental service that occurs at a Hospital or outpatient Surgery facility. 	<p>After Deductible met, Plan pays 90%</p>	<p>After Deductible met, Plan pays 50% of the surgical facility fee up to a maximum Plan payment of up to \$5,000 per operative session for Surgery- related services and supplies and up to \$3,500 for other outpatient department services and supplies per episode of treatment.</p>
<p><u>Prescription Drugs (Outpatient)</u></p>	<ul style="list-style-type: none"> See the Drug row for information on outpatient retail and mail order prescription medication. 		
<p><u>Preventive Care</u></p>	<ul style="list-style-type: none"> See the Wellness rows in this Schedule. 		
<p><u>Prosthetic Devices</u></p>	<ul style="list-style-type: none"> See the Corrective Appliances row in this Schedule. 		

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of- Network
<p><u>Radiology (X-Ray), Nuclear Medicine, Imaging Studies and Radiation Therapy Services (Outpatient)</u></p> <ul style="list-style-type: none"> Radiology refers to the branch of medicine using x-rays, radiopharmaceuticals (like radioisotopes, intravenous dye or contrast materials), magnetic resonance and ultrasound to create images (pictures) of the body that are used to help in the diagnosis and treatment of disease or injury. Common radiology services include chest x-ray, abdomen/kidney x-ray, spine x-ray, CT/MRI/PET and bone scan, ultrasound, angiography, mammogram, fluoroscopy, and bone densitometry. Technical and professional fees associated with diagnostic and curative radiology services, including radiation therapy. 	<ul style="list-style-type: none"> Preauthorization of complex diagnostic imaging tests such as PET scans is required by calling the Preauthorization Program whose contact information is listed on the Quick Reference Chart in the front of this document. See also Chapter 4 for details. Covered only when ordered by a Physician or Health Care Practitioner. Some Radiology procedures (such as a screening mammogram) are covered under the Preventive/Wellness Programs described in this Schedule. 	<p>After Deductible met, Plan pays 90%</p>	<p>After Deductible met, Plan pays 50%</p>
<p><u>Reconstructive Services and Breast Reconstruction After Mastectomy</u></p> <ul style="list-style-type: none"> This Plan complies with the Women's Health and Cancer Rights Act (WHCRA) that indicates that for any covered individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, including: <ul style="list-style-type: none"> reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications for all stages of mastectomy, including lymphedemas. <p>These benefits are covered applying the same cost-sharing as is relevant to other medical/surgical plan benefits.</p> Reconstructive Surgery only if such procedures or treatment are intended to improve bodily function, repair a functional defect and/or to correct deformity or disfigurement resulting from disease, infection, trauma, congenital anomaly or covered Surgery. 	<ul style="list-style-type: none"> The Plan covers replacement external breast prostheses and mastectomy bras when Medically Necessary. See the exclusions related to Cosmetic Services (including Reconstructive Surgery) in the Exclusions Chapter 6. Most Cosmetic and Dental (including Orthognathic) services are excluded from coverage. 	<p>After Deductible met, Plan pays 90%</p>	<p>After Deductible met, Plan pays 50%</p>

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<p><u>Rehabilitation Services: (Physical, Occupational & Speech Therapy)</u></p> <ul style="list-style-type: none"> Short term active, progressive Rehabilitation Services (Occupational, Physical, or Speech Therapy) performed by licensed or duly qualified therapists as ordered by a Physician. Inpatient Rehabilitation Services in an acute Hospital, rehabilitation unit or facility or Skilled Nursing Facility for short term, active, progressive Rehabilitation Services that cannot be provided in an outpatient or home setting. All benefits are subject to the limitations and the Maximum Plan Benefits shown in the Explanations and Limitations column. The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in an inpatient rehabilitation facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters. 	<ul style="list-style-type: none"> Preauthorization of an inpatient rehabilitation admission is required by calling the Preauthorization Program, whose contact information is listed on the Quick Reference Chart in the front of this document. See also Chapter 4 for details. Rehabilitation services, including Habilitation services, are covered when ordered by a Physician. The therapy must be rendered for the purpose of physical restoration of a physical disability for which there is a reasonable expectation of significant improvement in the status of that disability as determined by the Plan. Services must be certified by the Physician as Medically Necessary for the improvement of the patient's condition through short-term care. <ul style="list-style-type: none"> Inpatient Rehabilitation Services: benefit maximum is 30 days per Calendar Year. Outpatient Rehabilitation Services: <ol style="list-style-type: none"> Physical Therapy: benefit maximum is 20 sessions per Calendar Year. Occupational Therapy: benefit maximum is 20 sessions per Calendar Year. Speech Therapy: benefit maximum is 130 sessions per lifetime (whether or not there has been an interruption in coverage or change in eligibility status). To be covered, the speech therapy must be Medically Necessary to restore speech that was completely or severely impaired as a result of an accidental injury or illness, or develop speech in individuals whose inability to speak is the result of a hearing disorder. Speech therapy for minor speech impediments or for any other reason other than as outlined above is not covered. Not more than one visit is covered per day. No coverage for long term maintenance therapy or group exercise programs. See specific exclusions relating to Rehabilitation in the Exclusions Chapter 6 and the definition of Active, Passive and Maintenance Rehabilitation in the Glossary Chapter. 	<p>After Deductible met, Plan pays 90%.</p>	<p>After Deductible met, Plan pays 50%.</p>
<p><u>Skilled Nursing Facility (SNF) or Subacute Facility</u></p> <ul style="list-style-type: none"> Skilled Nursing Facility (SNF). Subacute Care Facility, also called Long Term Acute Care (LTAC) Facility. The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in a Skilled Nursing Facility or subacute facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters. 	<ul style="list-style-type: none"> Preauthorization of a Skilled Nursing Facility admission is required by calling the Preauthorization Program whose contact information is listed on the Quick Reference Chart in the front of this document. See also Chapter 4 for details. Services must be ordered by a Physician. Skilled Nursing Facility confinement or Subacute care facility confinement is payable up to 180 days per period of confinement. All confinements will be considered to have occurred during one period of confinement unless the confinements were due to entirely unrelated causes, or, complete recovery from the injury or sickness causing the previous confinement has taken place, or, in the case of an employee, the confinements are separated by a return to work for at least one regular working day, or, the confinements are separated by a period of 90 consecutive days. Benefits are payable if an Eligible Individual has been confined in an acute care (general) Hospital for at least 5 consecutive days and is then immediately transferred to a Skilled Nursing Facility (also referred to as an Extended Care Facility) for additional treatment or rehabilitation (this does not include Custodial Care). 	<p>No charge, Deductible does not apply for the first 30 days, thereafter, after Deductible met, Plan pays 90% for the next 150 days.</p>	<p>No charge, Deductible does not apply for the first 30 days, thereafter, after Deductible met, Plan pays 90% for the next 150 days.</p>

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<p><u>Smoking/Tobacco Cessation Benefits</u></p> <ul style="list-style-type: none"> This benefit can be used to help with nicotine addiction (to stop smoking or stop chewing tobacco). The Behavioral Health benefits of this Plan may be used for outpatient visits for smoking/tobacco cessation counseling. See the Behavioral Health row of this Schedule. 	<ul style="list-style-type: none"> Coverage is extended for over the counter or prescription tobacco cessation products (such as nicotine gum or patches) or counseling (by a licensed counselor) intended to assist an individual to stop smoking or using tobacco products. The Drugs are payable through the Prescription Drug Program at no charge. Present a written prescription from a network Physician for over the counter or prescription tobacco cessation products to the retail pharmacist. See the Drug row in this Schedule. The Plan covers: <ol style="list-style-type: none"> Screening for tobacco use; and, For those who use tobacco products, at least two (2) tobacco cessation attempts per year. Cessation attempt includes coverage for: <ul style="list-style-type: none"> Four (4) tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling with a licensed counselor) without prior authorization; and All FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization. 	<p>Tobacco cessation Counseling and medication: No charge. Deductible does not apply.</p>	<p>Tobacco cessation Counseling and medication: Not covered.</p>
<p><u>Spinal Manipulation Services</u></p> <ul style="list-style-type: none"> Spinal Manipulation Services (from a Physician – MD or DO, or Chiropractor) including related ancillary services (e.g., office visit, x-rays, is subject to the Annual Maximum Plan Benefit shown in the Explanations and Limitations column to the right. 	<ul style="list-style-type: none"> Spinal Manipulation by a Chiropractor, MD, or Doctor of Osteopathy (DO): maximum benefit is 24 visits per person per Calendar Year. Not more than one visit is covered per day. Spinal manipulation treatment does not accumulate to meet the Plan's annual Out-of-Pocket limit. 	<p>Spinal Manipulation by a Chiropractor: After Deductible met, Plan pays 100% up to a maximum of \$10 for each visit.</p> <p>Spinal Manipulation by a MD or DO: After Deductible met Plan pays 90%.</p>	<p>Spinal Manipulation by a Chiropractor: After Deductible met, Plan pays 100% up to a maximum of \$10 for each visit.</p> <p>Spinal Manipulation by a MD or DO: After Deductible met Plan pays 50%.</p>
<p><u>Substance Abuse/Substance Use Treatment</u></p>	<ul style="list-style-type: none"> See the Behavioral Health row of this Schedule. 		
<p><u>Tobacco Cessation Benefits</u></p>	<ul style="list-style-type: none"> See the Smoking/Tobacco Cessation Benefits row of this Schedule. 		

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This chart explains the benefits payable by the Plan. See also the Exclusions and Glossary Chapters of this document for important information. All benefits are subject to the Deductible except where noted. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Glossary Chapter, and could result in Balance Billing to you.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of- Network
<p>Transplants (Organ and Tissue)</p> <ul style="list-style-type: none"> Effective 1-1-19, coverage is provided for eligible services directly related to Medically Necessary and non-Experimental transplants of human organs or tissue, including but not limited to, bone marrow, peripheral stem cells, cornea, heart, heart/lung, intestine, islet tissue, kidney, kidney/pancreas, liver, liver/kidney, lung(s), pancreas, bone, tendons or skin, along with the facility and professional services, FDA approved Drugs, and Medically Necessary equipment and supplies. Organ/tissue Procurement is payable. Procurement includes expenses to find the donated organ/tissue (donor search fees), tests on the potential organ/tissue for compatibility, Surgery/procedures to remove the organ/tissue, preservation of the organ/tissue until it can be transplanted and transportation fees to deliver the organ/tissue to the patient/recipient. Reasonable and necessary medical expenses incurred by a donor who is covered by this Plan, are payable without any cost-sharing applicable to those expenses. Reasonable and necessary medical expenses incurred by a donor who is not covered by this Plan, are payable without any cost-sharing applicable to those expenses, but only to the extent the donor is not covered by the donor's own insurance or health care plan. Transplant related travel benefits are available for the patient and one family member or companion, when the approved transplant must occur 75 or more miles from the patient's residence, as outlined in the Explanations column to the right. 	<ul style="list-style-type: none"> Transplant services, including pre-transplant workup tests and transplant-related travel, require preauthorization by calling the Preauthorization Program, whose contact information is listed on the Quick Reference Chart in the front of this document. See also Chapter 4 for details. Transplant Related Travel Benefit: Certain travel expenses incurred in connection with an approved transplant performed at an approved health care facility that is 75 miles or more from the recipient's or donor's place of residence are covered, provided the expenses are preauthorized by the medical plan claims administrator. <ul style="list-style-type: none"> Maximum payment will not exceed \$10,000/transplant for travel expenses incurred by the recipient and one companion* or the donor. *Note: When the member recipient is under 18 years of age, this benefit will apply to the recipient and two caregiver companions. Ground transportation to and from the approved health care facility when it is 75 miles or more from the recipient's or donor's place of residence. Coach airfare to and from the approved health care facility when the designated facility is 300 miles or more from the recipient's or donor's residence. Lodging, limited to one room, double occupancy. Other reasonable expenses. Benefits for lodging and ground transportation provided up to the current limits set by the Internal Revenue Code. The annual Deductible will not apply and no Copayments will be required for transplant travel expenses preauthorized in advance by the claims administrator. Expenses incurred for the following are not covered: tobacco, alcohol, Drugs, meal expenses, interim visits to a medical care facility while waiting for the actual transplant procedure; travel expenses for a companion and/or caregiver for a transplant donor; return visits for a transplant donor for treatment of a condition found during the evaluation; rental cars; buses, taxis or shuttle services; and mileage within the city in which the medical transplant facility is located. Details regarding reimbursement can be obtained by calling the member services number on your identification card. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement. See the specific exclusions related to Experimental and Investigational Services and Transplants in the Exclusions Chapter 6. For Plan participants who serve as a donor, donor expenses are not payable unless the person who receives the donated organ/tissue is a person covered by this Plan. Expenses related to non-human (Xenografted) organ and/or tissue transplants or implants are excluded, except the Plan covers heart valves. 	<p>Physician services payable according to the Physician services row of this Schedule.</p> <p>Hospital services payable according to the Hospital row in this Schedule.</p>	<p>Physician services payable according to the Physician services row of this Schedule.</p> <p>Hospital services payable according to the Hospital row in this Schedule.</p>

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE ANTHEM MEDICAL PPO PLAN

This chart explains the benefits payable by the Plan. See also the Exclusions and Glossary Chapters of this document for important information. All benefits are subject to the Deductible except where noted. ***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Glossary Chapter, and could result in Balance Billing to you.**

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of-Network
<p><u>Weight Management Services</u></p> <ul style="list-style-type: none"> As a preventive counseling benefit in compliance with the Affordable Care Act (ACA), the Plan covers (for adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors) intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention. For children age 6 years and older with obesity, the Plan covers Physician prescribed intensive behavioral counseling interventions to promote improvement in weight status at the visit frequency recommended by the child's Network pediatrician. See the Wellness rows and Dietitian rows for more details. Weight loss Surgery (e.g. bariatric Surgery) is covered as explained to the right. 	<p>Effective 4-1-19, coverage is provided for a surgical procedure to promote weight loss (e.g. bariatric Surgery) when <u>ALL of the following criteria are met:</u></p> <ul style="list-style-type: none"> Surgery must be considered Medically Necessary and not be Experimental/Investigational/unproven as determined by the Plan Administrator or its Delegate. Weight loss (bariatric) Surgery requires preauthorization by calling the Preauthorization Program whose contact information is listed on the Quick Reference Chart in the front of this document. See also Chapter 4 for details. For coverage: <ul style="list-style-type: none"> Individual is morbidly obese with a body mass index (BMI) of 40 or greater, or a BMI of 35 or greater with at least two comorbidities such as diabetes or cardiopulmonary condition. Recommendation is received for Surgery from the patient's primary care Physician. Patient is approved under the requirements of the Plan's preauthorization process. Evidence of the patient's active participation in and documentation of prior non-surgical methods of weight loss. The individual is 18 years of age or older. Coverage is provided by Network Health Care Providers only. No bariatric Surgery coverage for Non-Network surgeons or facilities. There is a Copayment for bariatric Surgery. The Copay is generally payable to the Physician, not the facility. One bariatric surgical procedure is payable per person per lifetime. No coverage for skin reduction procedures/surgery related to weight loss. 	<p>After a \$2,500 Copay per Surgery per person, Physician services payable according to the Physician services row of this Schedule.</p> <p>Hospital services payable according to the Hospital row in this Schedule.</p>	<p>Not covered.</p>

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE ANTHEM MEDICAL PPO PLAN

This chart explains the benefits payable by the Plan. See also the Exclusions and Glossary Chapters of this document for important information. All benefits are subject to the Deductible except where noted. *IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Glossary Chapter, and could result in Balance Billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of-Network
<p><u>Wellness (Preventive) Program Well Child Examinations and Immunizations</u></p> <ul style="list-style-type: none"> • Outpatient newborn and well child visits and routine childhood immunizations that are FDA approved and in accordance with the Centers for Disease Control & Prevention (CDC) recommendations for children in the US, such as DPT, Polio, MMR, HIB, hepatitis, chickenpox, tetanus, influenza (flu) vaccine, HPV (e.g. Gardasil, Cervarix), etc. • Immunizations/Vaccinations Available from the Retail Pharmacy: The Plan covers immunizations obtained from a network retail pharmacy or during a network Physician office visit. • The wellness/Preventive Services payable by this Plan are designed to comply with Affordable Care Act (ACA) regulations as outlined to the right. • Preventive services are payable without regard to gender assigned at birth, or current gender status. • For children age 6 years and older with obesity, Plan covers Physician prescribed intensive behavioral counseling interventions to promote improvement in weight status at the visit frequency recommended by the child's Network pediatrician. • When performed in primary practices, topical fluoride varnish to the primary teeth of children is payable through age 5 years. • See page 62 for information on payment of ACA-mandated Drugs. • If there is no network provider who can provide the Affordable Care Act (ACA) required wellness service, then Plan will cover the service when performed by an out-of-network provider without cost-sharing. 	<p>The wellness/Preventive Services payable by this Plan are designed to comply with Affordable Care Act (ACA) regulations and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), Bright Futures and the Centers for Disease Control & Prevention (CDC). These websites (periodically updated) list the types of payable Preventive Services, including immunizations: https://www.healthcare.gov/what-are-my-preventive-care-benefits/ with more details at http://www.cdc.gov/vaccines/schedules/hcp/index.html, http://www.hrsa.gov/womensguidelines/ and https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/ (A and B rated recommendations).</p> <ul style="list-style-type: none"> • In addition to the wellness services listed on the websites above, the Plan will pay for these wellness services: well child office visits, well woman office visits, female contraceptives, and certain over-the-counter Drugs. • When both Preventive Services and diagnostic or therapeutic services occur at the same visit, you pay the cost share (e.g. Deductible, Copay, Coinsurance) for the diagnostic or therapeutic services but not for the Preventive Services. When a preventive visit turns into a diagnostic or therapeutic service in the same visit, then cost-sharing (e.g. Deductible, Copay, Coinsurance) will apply to the diagnostic or therapeutic services provided. • Preventive services are considered for payment when billed under the appropriate Preventive Service codes (benefit adjudication depends on accurate claim coding by the providers). If the billing for a wellness service is submitted to the claims administrator with a diagnosis code other than "wellness," claims will be processed under the Plan's usual cost-sharing including Deductible/Copay/Coinsurance. • Services not covered under the wellness/preventive benefit may be covered under another portion of the medical plan. Additional diagnostic services that are Medically Necessary because of the patient's medical diagnosis are covered, subject to the Plan's Deductibles, Coinsurance or Copayments, and all other Plan provisions. • If an Affordable Care Act (ACA) Preventive Service recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the Plan will use reasonable medical management techniques (such as age, frequency, location, method) to determine coverage parameters. The frequency for Affordable Care Act (ACA) Preventive Service recommendation is specified in these websites: https://www.healthcare.gov/what-are-my-preventive-care-benefits/, http://www.cdc.gov/vaccines/schedules/hcp/index.html, http://www.hrsa.gov/womensguidelines/, and http://www.uspreventiveservicestaskforce.org/BrowseRec/Index. The frequency of preventive visits for children is payable in accordance with the "Recommendations for Preventive Pediatric Health Care" from Bright Futures/American Academy of Pediatrics, updated periodically, (website for the schedule is: https://www.aap.org/en-us/Documents/periodicity_schedule.pdf). Note that for females, in accordance with the Affordable Care Act (ACA), the Plan will pay both a preventive office visit and a well woman office visit in a Calendar Year. • Where the information in this document conflicts with newly released Affordable Care Act regulations affecting Preventive Care coverage, this Plan will comply with the new requirements on the date required. • No coverage for immunizations/vaccines specifically required for travel or work (which are not otherwise CDC-recommended in the US). 	<p>No charge, Deductible does not apply.</p>	<p>After Deductible met, Plan pays 50%.</p>

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE ANTHEM MEDICAL PPO PLAN

This chart explains the benefits payable by the Plan. See also the Exclusions and Glossary Chapters of this document for important information. All benefits are subject to the Deductible except where noted. *IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Glossary Chapter, and could result in Balance Billing to you.

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of-Network
<p>Wellness (Preventive) Program: Adult Health Maintenance Examinations (Age 18 & up)</p> <ul style="list-style-type: none"> The wellness/Preventive Services payable by this Plan are designed to comply with Affordable Care Act (ACA) regulations as outlined to the right. Certain prescription and non-Prescription Drugs, required to be covered in compliance with Affordable Care Act (ACA), are available through the Outpatient Prescription Drug program. Health care billed as wellness is payable for the following services: Annual routine preventive health exam. Women are permitted to receive an annual routine gynecology (GYN) health exam in addition to the annual routine preventive health exam. Adult immunizations that are FDA approved and in accordance with the Centers for Disease Control & Prevention (CDC) recommendations for adults in the US, such as annual flu shot, HPV vaccine (e.g. Gardasil, Cervarix), shingles vaccine, etc. Colon cancer screening is payable for adults age 50 and older, including fecal occult blood test annually, stool DNA testing like Cologuard annually, AND screening colonoscopy (including anesthesia services) every 10 years, or any of these tests once every five (5) years: virtual screening colonoscopy, double contrast barium enema, or flexible sigmoidoscopy. No charge for a specialist pre-procedure consultation, bowel prep medication used prior to a screening colonoscopy, anesthesia services, or the lab charges for analysis of polyps removed during a screening colonoscopy. Screening Mammogram every other year for females age 50-74. As a preventive counseling benefit in compliance with Affordable Care Act (ACA), the Plan covers the following services for adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors: intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention. See page 62 for information on ACA-mandated Drugs. 	<p>The wellness/Preventive Services payable by this Plan are designed to comply with Affordable Care Act (ACA) regulations and the current A and B recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), Bright Futures, & the Centers for Disease Control & Prevention (CDC). These websites (periodically updated) list the types of payable Preventive Services (such as immunizations, mammogram, pap smear, screening colonoscopy with anesthesia and colon polyp removal): https://www.healthcare.gov/what-are-my-preventive-care-benefits with more details at: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/, http://www.cdc.gov/vaccines/schedules/hcp/index.html, and http://www.hrsa.gov/womensguidelines/.</p> <ul style="list-style-type: none"> In accordance with the Affordable Care Act (ACA), certain additional Preventive Care expenses are payable for all covered females as listed on the government websites at http://www.hrsa.gov/womensguidelines/ or https://www.healthcare.gov/what-are-my-preventive-care-benefits including but not limited to well woman office visits, screening for gestational diabetes, Genetic Counseling for females at risk for breast cancer, BRCA breast cancer gene test, HPV testing at least every 3 years starting at age 30, counseling on sexually transmitted infections, annual HIV screening and counseling, breastfeeding equipment and supplies needed to operate equipment, lactation support. See also the Durable Medical Equipment and Maternity Services rows in this Schedule. If a preventive item or service is billed separately from an office visit, then the Plan will impose cost-sharing with respect to the office visit. If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is the delivery of a Preventive Service, then the Plan will pay 100% for the office visit. If the Preventive Service is not billed separately from the office visit, and the primary purpose of the office visit is not the delivery of a Preventive Service, then the Plan will impose cost-sharing for the office visit. For example, if a person has a cholesterol screening test during an office visit, and the doctor bills for the office visit and separately for the cholesterol screening lab test, the Plan will charge cost-sharing (e.g. Deductible, Copay, Coinsurance) for the office visit but not for the cholesterol screening lab test. Preventive services are considered for payment when billed under the appropriate Preventive Service codes (benefit adjudication depends on accurate provider claim coding). If the billing for a Preventive Service is submitted to the claims administrator with a diagnosis code other than "wellness," claims may be processed under the Plan's usual non-preventive cost-sharing. Services not covered under the preventive benefit may be covered under another portion of the medical plan. Additional diagnostic services that are Medically Necessary because of the patient's medical diagnosis may be covered subject to the Plan's Deductibles, Coinsurance or Copayments, and all other Plan provisions. If an Affordable Care Act (ACA) Preventive Service recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the Plan will use reasonable medical management techniques (such as age, frequency, location, method) to determine coverage parameters. If there is no Network provider who can provide the Affordable Care Act (ACA) required wellness service, then the Plan will cover the service when performed by an out-of-network provider without cost-sharing. Where the information in this document conflicts with newly released Affordable Care Act regulations affecting Preventive Care coverage, this Plan will comply with the new requirements on the date required. Preventive services are payable without regard to gender assigned at birth, or current gender status. No coverage for immunizations/vaccines specifically required for travel or work (which are not otherwise CDC-recommended in the US). 	<p>No charge, Deductible does not apply.</p>	<p>After Deductible met, Plan pays 50%.</p>

Chapter 6: EXCLUSIONS FOR THE ANTHEM MEDICAL PPO PLAN

This Chapter includes information on:

- **Services, supplies, expenses or Drugs not covered by the Anthem Medical PPO Plan**

The following is a list of services and supplies or expenses **not covered (excluded) by the Anthem Medical PPO Plan**. See also the specific exclusions related to Dental, Vision, and Life Insurance benefits located in their respective chapters in this document.

The Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan.

General Exclusions are listed first followed by specific medically related Plan exclusions.

General Exclusions (applicable to all medical services and supplies)

1. **Autopsy:** Expenses for an autopsy, forensic examination and any related expenses, except as required by the Plan Administrator or its Delegate.
2. **Costs of Reports, Bills, etc.:** Expenses for preparing or completing forms, medical/dental reports/records, bills, disability/sick leave/claim forms and the like; mailing, shipping or handling expenses; and charges for broken/missed appointments, telephone calls, e-mailing charges, prescription refill charges, disabled person license plates/automotive forms, interest charges, late fees, mileage costs, provider administration fees, concierge/retainer agreement/direct primary care fees, membership/surcharge fees or provider's special plan charging fees to access added benefits and/or photocopying fees.
3. **Court Ordered:** Expenses for court-ordered services, unless the services are both Medically Necessary and a covered benefit of the Plan.
4. **Custody/Adoption:** Expenses for parental custody services or adoption services.
5. **Day Pass Fees:** Benefits will not be paid for any day in which the patient is released from the Hospital/health care facility on a temporary pass (also called a day pass).
6. **Educational Services:** Even if they are required because of an injury, illness or disability of a Covered Individual, the following expenses are not payable by the Plan: educational services, supplies or equipment, including, but not limited to computers, computer devices/software, printers, books, tutoring or interpreters, visual aids, auditory or speech aids/synthesizers, auxiliary aids, communication boards, listening systems, device/programs/services for behavioral training including intensive intervention programs for behavior change and/or developmental delays or auditory perception or listening/learning skills (except that programs based on learning theories and motivation such as applied behavior analysis therapy are payable), programs/services to remedy or enhance concentration, memory, motivation, reading or self-esteem, etc., special education and associated costs in conjunction with tactile systems like Braille or sign language education for a patient or family members, and implantable medical identification/tracking devices.

7. **Expenses Exceeding Maximum Plan Benefits:** Expenses that exceed any Plan benefit limitation or Maximum Plan Benefit as described in the Schedule of Medical Benefits section of this document.
8. **Expenses Exceeding Allowed Charges:** Any portion of the expenses for covered medical services or supplies that are determined by the Plan Administrator or its Delegate to exceed the Allowed Charge (as defined in the Glossary Chapter of this document) or are in excess of a specific Plan limit on Allowable Charges.
9. **Expenses for Which a Third Party Is Responsible:** Expenses for services or supplies for which a third party is required to pay are not covered. Expenses (past, present or future) for which another party is required to pay (e.g. no fault, personal injury protection, etc.) are not covered. See the provisions relating to Third Party Liability in Chapter 9. The Plan excludes any benefit that otherwise would be available, if the Trust determines that payment has already been made or is likely to be made for same from a third party. For example, a personal injury lawsuit settlement that the Trust determines includes payments for future medical care.
10. **Expenses directly related to complications of a Non-Covered Service** (except the Plan does pay for covered services resulting from complications related to an approved Clinical Trial), as explained in the definition of Experimental in the Glossary Chapter. Directly related means that the care took place as a direct result of the non-covered service and would not have taken place without the non-covered service. No coverage treatment for complications or reversal of a procedure which is excluded under the Plan. No coverage for complications resulting from a Cosmetic Surgery or treatment that was primarily performed to preserve or improve appearance (except the Plan covers complications from breast reconstruction due to a mastectomy).
11. **Expenses Incurred Before or Incurred After Coverage:** Expenses for services rendered or supplies provided before the person became covered under the medical Plan; or after the date the person's coverage ends, except under those conditions described in the COBRA section of Chapter 3.
12. **Experimental and/or Investigational Services:** Expenses for any medical services or procedures, supplies, Drugs or medicines that are determined by the Plan Administrator or its Delegate to be Experimental and/or Investigational or Unproven as defined in the Glossary Chapter of this document. However, routine costs associated with an approved clinical trial will not be considered Experimental services.
13. **Fraud:** Fraud, misrepresentation or concealment whether with respect to Eligible Individual status or claims for benefits otherwise available under the Plan.
14. **Gene Therapy:** Expenses for or related to gene therapy (a technique that uses human genes to treat or prevent disease in humans which can include introducing human DNA into an individual to treat a disease).
15. **Hypnosis:** Expenses for hypnosis or hypnotherapy (following a hypnotic induction technique performed by the provider, hypnosis produces a wakeful state of focused attention and heightened suggestibility with diminished peripheral awareness).
16. **Illegal Act:** Care or treatment of injuries resulting from an Eligible Individual's commission of, or attempt to commit, an assault, or felony unless such injury is the result of domestic violence or the commission or attempted commission of an assault or felony is the direct result of an underlying health factor.
17. **Learning/Education:** Expenses for educational services related to reading, learning disorders, dyslexia, educational delays, or vocational disabilities.

18. **Medical Examination/Services:** Medical examinations, services and supplies not Medically Necessary, except:
- as provided under the Preventive Care Services benefit,
 - routine care rendered by and billed by a Hospital for a newborn Dependent child during Hospital confinement, and
 - as provided under the Hospice Care benefit.
19. **Medically Unnecessary Services:** Services or supplies determined by the Plan Administrator or its Delegate not to be Medically Necessary as defined in the Glossary Chapter of this document, except the Plan covers certain Preventive benefits as outlined in the Schedule of Medical Benefits. Medically Necessary includes wellness/Preventive Services as noted in the Schedule of Medical Benefits in this document and includes prophylactic Surgery/treatment that is determined to be Medically Necessary by the Plan Administrator or its Delegate. For example, Surgery to remove the breasts and/or ovaries of a woman who has a genetic mutation demonstrating a significant genetic or hereditary predisposition of breast and/or ovarian cancer, may be determined by the Plan Administrator or its Delegate to be Medically Necessary even though at the time the Surgery is to be performed there is no objective evidence of the presence of cancer. When a prophylactic mastectomy is determined to be Medically Necessary, the Plan complies with the Women's Health and Cancer Rights Act (WHCRA) in covering reconstruction. Reconstruction is explained in the Schedule of Medical Benefits in the Reconstructive Services row.
20. **Military service related injury/illness:** If an Eligible Individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan. The Plan does not cover services furnished by a Hospital or facility owned or operated by the United States Government or any State Government or any authorized agencies thereof or furnished at the expense of such Governments or Agencies except as required by federal law, or which are provided without cost by any municipal, county or other political subdivision.
21. **Modifications of Homes or Vehicles:** Expenses for construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability of a Covered Individual, including, without limitation, construction or modification of ramps, elevators, hand rails, shower/tub grab bars, chair lifts, ceiling mounted lifts, spas/hot tubs, air conditioning, dehumidification devices, asbestos removal, air filtration/purification, swimming pools, Emergency alert system, etc.
22. **Non-Hospital Location:** Expenses for treatment of medical/surgical and mental health/Substance Use Disorders in these non-Hospital settings: wilderness therapy program, outdoor Behavioral Health program, boot camp-type program, boarding school, military school, foster home/care, group home, memory care/dementia care facility, assisted living arrangement, half-way/quarter-way house, or sober living/transitional living environment. No coverage for expenses related to a nursing home (that is not a Skilled Nursing Facility), an assisted living arrangement or a memory care/dementia care facility.
23. **Non-Participating Provider Waived Cost Sharing.** For any cost sharing for which you are responsible to pay under the terms of the Plan (such as a Copayment, Deductible or Coinsurance) that is waived by a non-participating (non-network) provider.
24. **Occupational Illness, Injury or Conditions Subject to Workers' Compensation:** All expenses incurred by you or any of your covered Dependents arising out of or in the course of employment (including self-employment) if the injury, illness or condition is subject to coverage, in whole or in part, under any workers' compensation or occupational disease or similar law.
25. **Penal Institution/Jail:** Care or treatment in any penal institution or jail facility or jail ward of

any State or political subdivision.

26. **Personal Comfort Items:** Expenses for convenience, comfort, hygiene, or beautification including, but not limited to, care of family members while the Covered Individual is confined to a Hospital or other Health Care Facility or to bed at home, guest meals or beds, television, DVD/Compact disc (CD) and other similar devices, telephone, barber or beautician services, admission or bedside kits, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, or private room (only as Medically Necessary), etc.
27. **Provider Specific:** Any bodily injury or sickness for which the patient is **not under the care of a provider** who is recognized by the Plan as an eligible provider; or care or treatment provided by a Recognized Provider to the extent such care or treatment is **outside the scope of the Recognized Provider's license or certification** or, the care or treatment is **not a covered service** under the Plan or, care or treatment provided by a Recognized Provider if Plan benefits for such care or treatment are contingent upon specific professional credentials and the Recognized Provider does not meet those credentials.
28. **Service Animals/Support Animals/Horse Therapy:** Expenses for and related to **Service animals**, including an animal that has been individually trained to do work or perform a service or tasks for the benefit of an individual with a disability, such as seeing eye dogs, or other disability-assistance dogs/birds/miniature horses and the like, seizure detection animals, diabetes/low blood sugar detection animals, service monkeys, etc. No coverage for **psychological or physiological therapy (such as emotional support) animals**. The Plan also excludes service or therapy animal supplies, transportation and veterinary expenses. No coverage for expenses for or related to **equine (horse) assisted therapy**.
29. **Services Excluded Because of Failure to Follow Medical Advice**
 - a. **Failure to Comply with Medically Appropriate Treatment:** Expenses incurred by a covered individual who fails to comply with medically appropriate treatment, as determined by the Plan Administrator or its Delegate.
 - b. **Leaving a Hospital Contrary to Medical Advice:** Hospital or other Health Care Facility expenses if you leave the facility against the medical advice of the attending Physician.
30. **Services Provided Outside the United States:** Expenses for medical services or supplies rendered or provided outside the United States, except for treatment for a medical Emergency (as defined in the Glossary Chapter of this document) while you are traveling on business or vacation (attending school outside the United States does not qualify as traveling on business or vacation). If an Eligible Individual incurs Allowable Charges for Emergency health care outside the United States while traveling on business or vacation and pays the provider at that time, and if the provider's charge is \$50 or more, payment must be made by check, money order or credit card voucher (not cash) in order for the individual to receive reimbursement for eligible expenses from this Plan. A copy of your cancelled check, money order or credit card voucher and an itemized bill must be included with the claim along with the regular filing requirements when you submit it to the Claims Administrator for reimbursement. An itemized billing is required for any claim incurred outside the United States.
31. **Transportation:** Transportation other than by professional ground, sea or air ambulance. Expenses related to **ambulance transport that is not Medically Necessary** for the treatment of an Emergency condition, such as when the patient wants to be at a certain Hospital or facility for personal preference reasons, patient is in foreign country, or out of state, and wants to return home or wants to return to a network health care facility to continue non-Emergency treatment, the patient who is not having an Emergency condition wants to be transported from a health care

facility to home or from home to a health care facility, or the patient is deceased (i.e., transportation to the coroner's office or mortuary).

32. **Unpaid Claims:** Any unpaid claims you have with respect to which the administrative remedies under the Plan's Claims and Appeals procedures have not been exhausted and any claims that were denied in the course of exhaustion of such administrative remedies if an action to enforce such claims is not commenced under ERISA Section 502(a) not later than the first anniversary of the date of the written notice of decision on the second appeal denying the claim.
33. **Untimely Filed Claims:** Expenses for services or supplies that otherwise would be covered by the Medical Plan will not be covered or payable by the Plan if a claim for payment of such services **is not submitted to the Medical Plan Claims Administrator within 15 months** from the date that the service is rendered or the supply provided.
34. **War or Similar Event:** Expenses incurred as a result of an injury or illness due to any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or armed invasion, aggression, except as required by law.

Exclusions Applicable To Specific Medical Services And Supplies

A. Allergy/Alternative/Complementary Health Care Services Exclusions

1. Expenses for acupuncture and/or acupressure.
2. Expenses for chelation therapy, except the Plan covers Medically Necessary treatment of lead poisoning, acute arsenic, gold, mercury or diseases of excess copper or iron.

B. Corrective Appliances, Durable Medical Equipment and Nondurable Supplies Exclusions

1. Expenses for any **items that are not** Corrective Appliances, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment as each of those terms is defined in the Glossary Chapter of this document, including but not limited to air purifiers, swimming pools, spas, saunas, escalators, lifts, pillows, mattresses, water beds, and air conditioners.
2. Expenses for **replacement of lost, missing, or stolen, duplicate or personalized** Corrective Appliances, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment. See the Corrective Appliances row and Durable Medical Equipment row of the Schedule of Medical Benefits for information on repair, adjustment, servicing and replacement of a device under certain situations.

See also the Hearing Exclusions.

C. Cosmetic Services Exclusions

1. Cosmetic Surgery or treatment and any complications arising from such Surgery or treatment, except:
 - a. operations necessary to repair disfigurement due to an accident,
 - b. operations necessary to repair a congenital anomaly in a Dependent child, or
 - c. breast reconstruction following a mastectomy including reconstruction of the breast on which Surgery was performed, Surgery on the other breast to produce a symmetrical appearance, and prosthesis and physical complications of all stages of mastectomy, including lymphedemas.

Cosmetic Surgery or treatment includes Surgery or medical treatment to improve or preserve physical appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance, but not to treat physical function.

No benefits are available for Surgery or treatments to change the texture or look of the skin or to change the size, shape or look of facial or body features (including but not limited to the nose, eyes, ears, cheeks, chin, chest or breasts).

Note: The Medical Program **does** cover Medically Necessary Reconstructive Services. Reconstructive Surgery is payable only if required by law (e.g., breast symmetry after a mastectomy), or the procedure or treatment is intended to improve bodily function, repair a functional defect and/or to correct deformity or disfigurement resulting from disease, infection, trauma, congenital anomaly (birth defect) or covered Surgery. Plan Participants should use the Plan's Preauthorization procedure to determine if a proposed Surgery or service will be considered Cosmetic Surgery or will be considered as a Medically Necessary Reconstructive Service.

Cosmetic Surgery or Treatment that is not covered includes, but is not limited to:

- a. scar revision, unless Surgery is necessary to repair a disfigurement due to an accident or as a result of a congenital anomaly in a covered Dependent child.
- b. removal of tattoos, ear or body piercing, electrolysis hair removal
- c. breast augmentation or mastopexy (except the Plan covers reconstructive services after a mastectomy),
- d. breast reduction (including treatment of benign gynecomastia in males),
- e. removal of redundant or excessive skin including elimination of redundant skin of the abdomen, abdominoplasty, or skin reduction after weight loss,
- f. surgery to improve self-esteem or treat psychological symptoms or psychosocial complaints related to one's appearance,
- g. treatment of varicose veins,
- h. skin resurfacing, body sculpting, chemical skin peel, Cosmetic skin products such as Restylane and Renova, collagen and other filler injectable products such as Juvederm, Perlane, Radiesse,
- i. face, forehead, brow, eyelid (blepharoplasty) or neck lift; nose, lip, cheek, malar, or chin enhancement, reduction or implant; facial bone reduction,
- j. calf/buttocks/pectoral implants/lift/augmentation,
- k. liposuction body contouring,
- l. reduction thyroid chondroplasty,
- m. testicular implant (unless due to a congenital anomaly in a covered child)
- n. voice modification Surgery (laryngoplasty or shortening of the vocal cords), voice therapy/voice lessons,
- o. drugs for hair loss, hair growth, hair removal, hair implantation, or
- p. other medical or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its Delegate.

Cosmetic Surgery does not become reconstructive Surgery because of psychological reasons.

D. Custodial Care Exclusions

1. Any services furnished by an institution which is primarily a place of rest, a place for the aged, a nursing or convalescent home or any institution of like character, or in a sanitarium unless otherwise specifically provided under the Plan.
2. Custodial Care except as specifically provided under the Anthem Medical PPO Plan's hospice care benefits. (Be aware that the term "Custodial Care" has a special meaning-refer to the

Glossary Chapter. Among other things, care that simply maintains a person's condition or expr

3. makes the person more comfortable may be considered Custodial Care and not covered.)
4. Expenses for Custodial Care, as defined in the Glossary Chapter of this document, are excluded regardless of where they are provided, including, without limitation, adult day care, child day care, services of a homemaker, or housekeeper, or personal care, sitter/companion/caregiver service.
5. Services required to be performed by Physicians, Nurses or other skilled Health Care Providers are **not** considered to be provided for Custodial Care services, and are covered if they are determined by the Plan Administrator or its Delegate to be Medically Necessary. However, any services that can be learned to be performed or provided by a family member who is not a Physician, Nurse or other skilled Health Care Provider are **not covered**, even if they are Medically Necessary.

E. Dental Services Exclusions

1. Any operation or treatment in connection with the fitting or wearing of **dentures or for treatment of the teeth or gums**, except that Allowable Charges in connection with the following Medically Necessary treatment will be covered when rendered by a Physician or Dentist:
 - a. treatment of tumors or lesions,
 - b. treatment of accidental injury to teeth from an external cause, not associated with biting or chewing and fractures,
 - c. maxillofacial surgical procedures (reconstructive not Cosmetic) if performed by a qualified oral and maxillofacial surgeon, (such as for reduction of facial bone fractures, removal of jaw tumors, treatment of jaw dislocations, treatment of facial and oral wounds or lacerations or infections (cellulitis), and removal of cysts or tumors of the jaws/facial bones), **but not for treatment for Temporomandibular Joint Disorder/Syndrome (TMD/TMJ)**, and
 - d. services and supplies covered under the Hospital and anesthesia benefits for dental treatment that is required to be performed in a Hospital as determined by the Claims Administrator. In order for such services and supplies to be covered, preauthorization is required (see "Preauthorization" in Chapter 4) and the anesthesia services must be rendered by a Physician or CRNA.
2. Expenses for **Dental services or supplies** of any kind, (even if they are necessary because of symptoms, congenital anomaly, illness or injury affecting the mouth or another part of the body) including but not limited to dental prosthetics, dental implants, splints, retainers, oral appliances, orthodontia services, endodontics such as root canal, dental restorations, and dental services for the care, filling, removal or replacement of teeth, including removal of wisdom teeth, or the treatment of injuries to or disease of the teeth, gums or structures directly supporting or attached to the teeth (except the Plan covers accidental injury to teeth as explained in the Oral services row of the Schedule of Medical Benefits).

Expenses not covered under the Medical Plan also include dental services such as gingivectomy, procedures in preparation for future dental work or dental implants, (such as sinus lift, soft tissue graft, bone graft/replacement).

F. Drugs, Medicines and Nutrition Exclusions

1. Pharmaceuticals requiring a prescription that have not been approved by the US Food and Drug Administration (FDA) or are Experimental and/or Investigational as defined in the Glossary Chapter of this document.
2. Non-prescription (meaning non-legend or over-the-counter – OTC) Drugs or medicines, except the Plan covers insulin and syringes and certain OTC and prescription medication in accordance with Affordable Care Act (ACA) regulations, at no cost when prescribed by a Physician or Health Care Practitioner and filled at a network pharmacy.
3. Foods and nutritional/dietary supplements including, but not limited to, home meals, formulas, foods, diets, vitamins, herbs and minerals (whether they can be purchased over-the-counter or require a prescription), except the following are payable:
 - a. foods and nutritional supplements provided during a covered hospitalization,
 - b. when prescribed in compliance with Affordable Care Act (ACA) regulations,
 - c. nutritional support may be payable when it is determined by the Plan Administrator or its Delegate to be Medically Necessary, and is necessary to sustain life (is the sole or primary means of adequate nutritional intake) and is administered enterally (i.e., by feeding tube) or parenterally (i.e., by intravenous administration such as total parental nutrition/TPN) and is not a food thickener, infant formula, specialized infant formula, donor breast milk, baby food, or other non-prescription product/substance that can be mixed in a blender.
4. Naturopathic, naprapathic or homeopathic products and substances.
5. The following Drugs, medicines or devices:
 - a. male contraceptives, such as condoms;
 - b. fertility Drug products or agents;
 - c. dental products such as fluoride preparations, (except as required to be covered in compliance with the Affordable Care Act (ACA)) and products for periodontal disease;
 - d. hair removal or hair growth products (e.g., Propecia, Rogaine, Minoxidil, Vaniqa);
 - e. Gerovital, Geriatrium, and related anti-aging preparations;
 - f. injectable forms of treatment for male erectile dysfunction (e.g., Caverject); however, non-injectable forms are covered.
 - g. Cosmetic products, health and beauty aids, such as Restylane and Renova and collagen and other filler injectable products such as Juvederm, Perlane, Radiesse;
 - h. weight management (anti-obesity) products (e.g., Xenical, Contrave), except the Plan covers weight management Prescription Drugs that are being used as treatment of individuals with attention deficit hyperactivity disorder (ADHD) or individuals with narcolepsy.
 - i. any form of marijuana, medical marijuana or marijuana based product/oil/consumable, except, the Plan covers FDA-approved marijuana or derivatives of marijuana, such as tetrahydrocannabinol (e.g. Marinol), and cannabidiol (Epidiolex);
 - j. vitamins and dietary supplements (except as required by law),
 - k. Prescription Drug treatment for weight loss. This exclusion does not apply to the extent that weight management treatment constitutes ACA-mandated Preventive screening and

counseling for obesity or otherwise qualifies as an ACA-mandated Preventive Service (see the Wellness row of the Schedule of Medical Benefits).

6. Compound Prescription Drugs unless there is at least one ingredient that requires a prescription as defined by federal law.
7. Take-home Drugs or medicines provided by a Hospital, Emergency room, Ambulatory Surgical Facility/Center, or other Health Care Facility.
8. Vaccinations, immunizations, inoculations or preventive injections needed due to foreign/international travel such as for yellow fever or to protect against occupational hazards and risks. Note that certain vaccinations/immunizations are payable when required for the treatment of an injury or because of the participant's exposure to disease/infection (such as anti-rabies, tetanus, anti-venom, or immunoglobulin) and those routine immunizations provided under the Preventive benefits for children and/or adults as described in the Schedule of Medical Benefits in this document.
9. This Plan has adopted the Prescription Drug Program's current Formulary, including its preferred Drug list, as the Plan's covered Formulary of covered Drugs. Based on the Prescription Drug Program's Formulary (which is updated from time to time), certain Drugs are not covered by the Plan, or are covered only when they are pre-approved by the Prescription Drug Program. Contact Express Scripts for information about the Formulary or Drug Exception Process.

Drug Exception Process: The Plan has an exception process managed by the Prescription Drug Manager (whose contact information is listed on the Quick Reference Chart in the front of this document). The exception process allows a member's Physician to contact the Prescription Drug Manager to request that a non-covered Drug be payable under the Plan. The Physician is to fax the request for a Drug exception and the clinical reasons why the Drug is needed, including why a Formulary (Preferred Drug) cannot be used in its place, to the clinical team of the Prescription Drug Manager who will review and respond to the Physician with their determination.

G. Durable Medical Equipment Exclusions

See the Exclusions related to Corrective Appliances and Durable Medical Equipment.

H. Fertility and Infertility Services Exclusions

1. Any services or supplies in connection with the **treatment of infertility**, including, but not limited to, artificial insemination, in vitro fertilization, reversal of sterilization and hormone therapy, Prescription Drugs to promote fertility, procedures or devices to achieve fertility; in vitro fertilization (IVF); low tubal transfer; embryo transfer; gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT); collection/storage/purchase of donor egg/semen; cryostorage (freezing) of egg/sperm; ovarian transplant; infertility donor expenses; fetal implants; fetal reduction services; other surgical impregnation procedures, and expenses for and related to adoption. Note that the diagnosis of infertility is a covered benefit as explained in the Family Planning row of the Schedule of Medical Benefits.

I. Foot Care/Hand Care Exclusions

1. Expenses for **routine foot care**, (routine foot care includes but is not limited to hygienic cleaning of the feet with trimming of toenails, removal or reduction of corns and callouses, removal of thick/cracked foot skin, Preventive Care with assessment of pulses, skin condition and sensation). Routine foot care administered by a licensed medical professional including

a Podiatrist is payable when Medically Necessary for individuals with diabetes or a neurological or vascular insufficiency affecting the feet.

2. Expenses for hand care including manicure and skin conditioning and other hygienic/Preventive Care performed in the absence of localized illness, injury or symptoms involving the hand, unless the Plan Administrator or its Delegate determines such care to be Medically Necessary.

J. Genetic Testing and Counseling Exclusions

1. **Genetic Testing:** The following expenses for Genetic Tests are not covered, including obtaining a specimen and laboratory analysis to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics. (Certain Genetic Tests are covered as listed as payable in the Genetic Testing row in the Schedule of Medical Benefits.) Genetic services that are **not covered** include:
 - a. **Pre-parental Genetic Testing** (also called carrier testing) intended to determine if an individual (such as a prospective parent) is at risk of passing on a particular genetic mutation (at risk for producing affected children);
 - b. Expenses for **Pre-Implantation Genetic Diagnosis (PGD)** where one or more cells are removed from an embryo and genetically analyzed to determine if it is normal in connection with in vitro fertilization;
 - c. No coverage of Genetic Testing of Plan participants if the testing is performed primarily for the medical management of family members who are not covered under this Plan. Genetic testing costs may be covered for a non-covered family member only if such testing would directly impact the Medically Necessary treatment of a Plan participant;
 - d. **Paternity testing and Direct to Consumer (DTC) Genetic Testing kits/services** are not covered.
 - e. Genetic testing determined by the Plan Administrator or its Delegate to be **not Medically Necessary or is determined to be Experimental or Investigational**.

See the Genetic Services row of the Schedule of Medical Benefits for a description of the genetic services that are covered by the Plan.

Plan Participants should contact the Anthem Medical PPO Plan Claims Administrator for assistance in determining if a proposed Genetic Test will be covered or excluded.

2. **Genetic Counseling:** Expenses for Genetic Counseling are not covered, unless these three conditions are met: a) is ordered by a Physician, and b) performed by a qualified Genetic Counselor (or other qualified health care provider) and c) performed with regard to a Genetic Test that is payable by this Plan.

K. Hair Exclusions

1. Drugs or devices as a treatment for Alopecia (loss of hair). Expenses for and related to hair removal or hair transplants and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-Prescription Drugs such as Minoxidil, Propecia, Rogaine, Vaniqa; or expenses for and related to hair replacement including, but not limited to, devices, wigs, toupees, hairpieces, hair cranial prosthesis, or hair analysis, (except that the Plan will provide benefits for a single wig, toupee or hairpiece as described in the Corrective Appliances section of the Schedule of Medical Benefits).

L. Hearing Care Exclusions

1. No coverage for charges for a hearing aid which exceeds the device prescribed for the correction of hearing loss, or a hearing aid that is not Medically Necessary. See also the Hearing Services row in the Schedule of Medical Benefits.

M. Home Health Care Exclusions

1. Expenses for any Home Health Care services other than part-time, intermittent **skilled nursing** services and supplies.
2. Expenses under a Home Health Care program for services that are provided by someone who is not acting under the scope of their license and who ordinarily lives in the patient's home or is a parent, Spouse, sibling by birth or marriage, or child of the patient; or when the patient is not under the continuing care of a Physician.
3. Expenses for a homemaker, Custodial care, child care, adult day care, caregiver or personal care attendant services, except as provided under the Plan's Hospice coverage.

N. Maternity/Family Planning/Contraceptive Exclusions

1. Medical services or supplies for surrogate mothers, except that if the **surrogate mother** is an Eligible Individual under this Plan. Medical expenses otherwise covered by the Plan which are incurred with respect to a pregnancy will be covered in accordance with the terms of the Plan (including coordinating benefits if the Eligible Individual is also covered by another group plan) unless the Eligible Individual is receiving remuneration for surrogate motherhood or their medical expenses for pregnancy are being paid by another individual or entity.
2. **Contraception:** Expenses related to non-prescription contraceptive Drugs and devices for males, such as condoms.
3. **Termination of Pregnancy:** Expenses for elective induced (voluntary) abortion for a covered Dependent child.
4. Expenses related to the **maternity care that is not mandated by ACA, and delivery expenses associated with a pregnant Dependent child or former Dependent child who is a COBRA participant.** This exclusion of maternity care for a pregnant Dependent child does not apply to the extent the expenses qualify as prenatal and postnatal care provided under the Preventive Services row of the Schedule of Medical Benefits, but the exclusion does apply to maternity services that are not office visits such as ultrasounds and delivery expenses.
5. Expenses related to **cryostorage of umbilical cord blood or other tissue or organs, or expenses related to storage and shipping of breast milk.**

For Nondurable supplies (see Corrective Appliances)

O. Rehabilitation Therapy Exclusions (Inpatient or Outpatient)

1. Long-term maintenance therapy or group exercise programs.
2. Health club memberships, and the purchase and/or rental of exercise and health equipment even if the activities were recommended by a Physician (such as exercise, swimming, massage, etc.)
3. Recreational therapy, educational therapy, occupational therapy (unless the therapy is deemed physical therapy by the Trust and it meets the requirements for coverage under the Plan's physical therapy benefits), job training, vocational rehabilitation or forms of non-medical, self-care or self-help training, and any related diagnostic testing.

4. Expenses for massage therapy, rolfing (deep muscle manipulation and massage), craniosacral therapy (noninvasive rhythmic manipulation of the craniosacral areas) and related services.
5. Expenses incurred at an inpatient rehabilitation facility for any inpatient Rehabilitation Therapy services provided to an individual who is unconscious, comatose, or in the judgment of the Plan Administrator or its Delegate, is otherwise incapable of conscious participation in the therapy services and/or unable to learn and/or remember what is taught, including, but not limited to coma stimulation programs and like services.
6. Speech therapy is not considered Medically Necessary and is not a covered benefit for **self-correcting dysfunctions** causing dysfluency or articulation disorders such as **stuttering, stammering, lisping and tongue thrusting**, defects in voice quality such as in pitch, loudness, or to improve public speaking, or for conditions of psychoneurotic origin.
7. Rehabilitation services that do not require the skills of a licensed therapist, and/or Rehabilitation Services performed when there is no expectation of significant improvement.

P. Sexual/Erectile Dysfunction Services Exclusions

1. **Treatment of Erectile Dysfunction (Impotency):** Expenses for injectable Prescription Drugs (e.g. Caverject, Edex, Prostin VR) and/or other medical or surgical treatment of erectile dysfunction or inadequacy including but not limited to implants, devices or preparations to correct or enhance erectile function, sensitivity, or alter the shape or appearance of a sex organ, diagnostic or confirmatory laboratory testing such as blood flow studies, tumescence testing, ultrasound, hormonal blood levels. Note that non-injectable treatment of erectile dysfunction is covered as explained in the Family Planning row of the Schedule of Medical Benefits.
2. **Treatment of Gender Dysphoria/Gender Incongruence:** Any services or supplies in connection with changing the physical characteristics of an Eligible Individual to those of the opposite sex (this includes any medical, surgical or mental health treatment or study related to sex change). Expenses for medical, surgical or Prescription Drug treatment related to treatment of gender dysphoria, gender incongruence including transgender, transsexual, gender reassignment (sex change) procedures, or the preparation for such procedures, or any complications resulting from such procedures or reversal of any such procedures.
3. Surgery to reverse a prior genital Surgery or reversal of Surgery to revise secondary sex characteristics (physical changes related to puberty).

Q. Sleep Disorders/Snoring/Obstructive Sleep Apnea

1. Expenses related to the medical or surgical treatment of sleep disorders or snoring including medical equipment and oral appliances; **however, the Plan will cover** diagnostic sleep studies and Medically Necessary treatment of documented obstructive sleep apnea (OSA).

R. Transplant (Organ and Tissue) Exclusions

1. Expenses for human organ and/or tissue transplants that are not Medically Necessary or are Experimental and/or Investigational, including, but not limited to, donor screening, acquisition and selection, organ or tissue removal, transportation, transplants, postoperative services and Drugs/medicines and all complications thereof. Note that the Plan covers Transplant Services as listed under Transplantation in the Schedule of Medical Benefits.
2. For Plan participants who serve as a donor, donor expenses are not payable by this Plan unless the person who receives the donated organ/tissue is a person covered by this Plan.
3. Expenses related to non-human (Xenografted) organ and/or tissue transplants or implants, except the Plan covers heart valves.

S. Vision Plan Exclusions

1. Expenses for diagnosis and treatment of refractive errors, including eye examinations, purchase, fitting and repair of eyeglasses or lenses, or contact lenses, the fitting of contact lenses, and associated supplies. See the Corrective Appliances row in the Schedule of Medical Benefits for information on the coverage of eyeglasses or contact lenses after Surgery to remove the lens of the eye.
2. Surgical correction of refractive errors including but not limited to LASIK or similar procedures, except when the patient's myopia cannot be corrected to 20/40 or better by eyeglasses or contact lenses. (Covered Surgery is limited to one Surgery for each eye during a person's lifetime, up to a maximum payment of \$1,000 for each Surgery.)
3. Vision therapy (orthoptics) and supplies, except when necessary in lieu of a surgical eye procedure.

T. Weight Management and Physical Fitness Exclusions

1. Prescription Drug treatment for weight loss. This exclusion does not apply to the extent that weight management treatment constitutes ACA-mandated Preventive screening and counseling for obesity or otherwise qualifies as an ACA-mandated Preventive Service (see the Wellness row of the Schedule of Medical Benefits).
2. Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment, fitness instructors, work hardening and/or weight training services, ergonomic chairs/desks, exercise/activity/health monitoring/tracking devices, or software applications including smartwatches/jewelry and wireless or wearable sensors trackers.

Chapter 7: DENTAL PLAN OPTIONS

This Chapter includes information on:

- Dental Plan options
- A Schedule of Dental Benefits
- Dental Plan limitations and exclusions
- How to file a dental claim

Dental Plan coverage (provided through UnitedHealthcare Dental) is available to Eligible Individuals enrolled in the Kaiser Deductible HMO Medical Plan or the Anthem Medical PPO Plan.

The insured UnitedHealthcare Dental Plan options are considered an excepted benefit under the Affordable Care Act (ACA).

The information in this Chapter is a summary of your insured Dental Plan options. Further details on the coverage are found in the benefit material issued by UnitedHealthcare Dental. Where the information in this Chapter deviates from the certificate of coverage and summary of benefits produced by the insurance company, the insurance company documents will prevail. If you need a copy of the benefit material, contact the Administrative Office.

Dental Plan Options

Eligible employees and their eligible Dependents have access to select from various Dental plan options. There are three Dental Plans offered to eligible Plan participants based on where you live (refer to the “Availability” chart below):

- Select Managed Care Direct Compensation (DC) Dental Plan** (an insured Dental plan). This is the default Dental Plan (meaning that when you are eligible for Dental benefits you will automatically be enrolled into this Dental plan unless you make an election for the DPPO plan, noted below).
- In-Network Only (INO) Dental Plan** (an insured Dental plan with in-network providers only).
- Dental Preferred Provider Organization (DPPO) Plan** (an insured Dental plan with in-network and non-network providers).

AVAILABILITY OF DENTAL PLAN IN A STATE LOCATION			
Residents of:	Select Managed Care Direct Compensation (DC) Dental Plan	In-Network Only (INO) Dental Plan	Dental Preferred Provider Organization (DPPO) Plan
Arizona	--	X	X
California	X (in-network only)	--	X
Colorado	--	X	X
Nevada	X (a PPO plan design)	--	X
New Mexico	--	--	X
Texas	--	--	X

AVAILABILITY OF DENTAL PLAN IN A STATE LOCATION			
Residents of:	Select Managed Care Direct Compensation (DC) Dental Plan	In-Network Only (INO) Dental Plan	Dental Preferred Provider Organization (DPPO) Plan
Utah	--	X	X
Wyoming	--	X	X
Other States	--	X (available in most states)	X

More information about the Dental Plans is available from the Administrative Office and UnitedHealthcare (contact information is listed on the Quick Reference Chart at the front of this document).

Dental Network

All the Dental Plan options include a network of dental providers. Network providers (licensed Dentists and dental hygienists) have a contract with the UnitedHealthcare Dental network to provide discounted fees to you for services covered under the Dental Plan. By using the services of a network provider, both you and the Plan pay less. A current list of network dental providers is available free of charge when you contact the Dental Plan, whose name, telephone number and website are listed on the Quick Reference Chart in the front of this document.

To receive services, simply call a network dental provider and identify yourself as a member of this Dental Plan.

Some of the Dental Plan options permit reimbursement if you use a dental provider who is out-of-network. This means the provider is not contracted with the dental network, may not extend a discount off their services to you and can Balance Bill you for any balance that may be due in addition to the Allowed Charge amount payable by the Plan.

Eligible Dental Expenses

You are covered for expenses you incur for most, but not all, dental services and supplies provided by a Dental Care Provider that are determined to be “**Medically Necessary,**” but only to the extent that:

- the Dental Plan determines that the services are the most cost-effective ones that **meet acceptable standards of professional dental practice** producing a satisfactory result; **and**
- services are not **Experimental or Investigational; and**
- **services or supplies are not excluded** from coverage (as provided in the Dental Plan Limitations and Exclusions section of this Chapter); and
- **services or supplies are not in excess** of a Maximum Plan Benefit as shown in the Schedule of Dental Benefits in this Chapter; and
- the charges for dental services are an “**Allowed Charge.**” See the Glossary Chapter under “Allowed Charge.”

Note that the Anthem Medical PPO Plan Deductible and Anthem Medical PPO Plan Out-of-Pocket Limit do not apply to (or accumulate) Dental Plan benefits and vice versa.

The Plan will not reimburse you for any expenses that are not Eligible Dental Expenses. That means you must pay the full cost for all expenses that are not covered by the Plan, as well as any charges for Eligible Dental Expenses that exceed the amount determined by the Plan to be Allowed Charge.

Cost-Sharing for Covered Dental Services

Cost-sharing refers to how you and the Dental Plan split the cost for covered dental expenses. There are three types of cost-sharing applicable to the various Dental Plan Options: Deductibles, Copayments/Copays and Coinsurance. These are explained below in more detail and on the Schedule of Dental Benefits. Cost-sharing does not refer to premiums or contributions for coverage, Balance Billing amounts, or non-covered/excluded dental expenses.

✓ **Deductible (when applicable)**

When the Dental Plan includes an annual Deductible, each Calendar Year you are responsible for paying all your Eligible Dental Expenses until you satisfy the annual Deductible. Then, the Dental Plan begins to pay benefits.

- The amount of the **Dental Plan Deductible (when applicable) is listed on the Schedule of Dental Benefits.**
- Note that Eligible Dental Expenses incurred for Preventive Services are not subject to the Dental Plan Deductible.

✓ **Copayment/Copay (when applicable)**

A Copayment (or Copay, as it is sometimes called) is a set dollar amount you (and **not** the Dental Plan) are responsible for paying when you incur certain Eligible Dental Expenses. See the Schedule of Dental Benefits for information on which Dental Plan has Copayments.

✓ **Coinsurance (when applicable)**

Coinsurance is how you and the Dental Plan will split the cost of certain covered dental expenses, after the Deductible is met. Once you've met your annual Deductible (when applicable), the Plan pays a percentage of the Eligible Dental Expenses, and you are responsible for paying the rest. The applicable percentage paid by you (the Coinsurance) is shown in the Schedule of Dental Benefits.

Annual Maximum Dental Plan Benefits (when applicable)

The Annual Maximum Dental Plan Benefit payable for any individual covered under the Dental Plan per Calendar Year is displayed on the Schedule of Dental Benefits. Once the annual maximum is reached the Dental Plan will pay no more dental benefits until the start of the new Calendar Year.

Overall Lifetime Maximum Plan Benefits for Orthodontia Services

Some Dental Plans include a Lifetime Maximum Plan Benefit payable for Orthodontia services, which is displayed on the Schedule of Dental Benefits.

Schedule of Dental Plan Benefits

A schedule of the Plan's Dental Plan Options appear on the following page in a chart format. In the Schedule of Dental Benefits you will find information about the Dental Plan Options. You will see if there is an annual maximum applied for dental benefits, Deductibles (when applicable), along with highlights about Preventive dental care and Basic, Major and Orthodontia dental services.

All benefits shown in the Schedule of Dental Benefits are subject to the Dental Plan's Deductible unless there is a specific statement that a Deductible does not apply. For more detailed information about Dental plan benefits refer to the documents provided to you by the Dental Plan in which you are enrolled.

Schedule Of Dental Benefits (This chart notes what you pay.)

Benefit Description	Dental Preferred Provider Organization (DPPO) Plan (Available in AZ, CA, CO, NV, NM, TX, UT, WY, & other states)		In-Network Only (INO) Dental Plan (Available in AZ, CO, UT, WY & most other states)	Select Managed Care Direct Compensation (DC) Plan (Available in CA & NV)	
	In-Network Providers	Out-of-Network Providers	In-Network Providers	In-Network Providers	Out-of-Network Providers
Annual Calendar Year Dental Plan Maximum Benefit	\$2,000 per person		\$5,000 per person.	No annual maximum.	
Annual Calendar Year Deductible	\$50/person \$150/family	\$50/person \$150/family	No Deductible.	No Deductible.	
Referral Needed to See a Specialist Dental Provider?	No		No	Yes	
Diagnostic and Preventive Services: Preventive includes exam and routine dental cleanings 2 times per 12 months, bitewing x-rays 1 per Calendar Year. Diagnostic services include topical fluoride, sealants, and space maintainers.	No charge. Deductible does not apply to Preventive Services.	50%* Deductible does not apply to preventive services.	No charge, Deductible does not apply to Preventive Services.	No charge, Deductible does not apply to Preventive Services. Extra dental visits are covered during pregnancy and the first 3 months after birth.	California residents: Not covered. Nevada residents: Plan pays up to a maximum amount for each dental service. For example, the Plan pays up to \$25 for an oral exam or up to \$25 for a dental cleaning.
Basic Services such as a filling, tooth extraction	50% of the discounted network amount after Deductible met.	50% of the <u>non-discounted</u> Allowed charge after Deductible met.	Variable Copays can apply. For details visit https://welcometouhc.com/csac or call 1-800-445-9090.	Variable Copays can apply. For details visit https://welcometouhc.com/csac or call 1-800-445-9090.	California residents: Not covered. Nevada residents: variable Copays can apply. For details visit https://welcometouhc.com/csac or call 1-800-445-9090.
Major Services such as root canal, crowns, oral Surgery, dentures/bridges	50% of the discounted network amount after Deductible met.	50% of the <u>non-discounted</u> Allowed charge after Deductible met.	Variable Copays can apply. For details visit https://welcometouhc.com/csac or call 1-800-445-9090.	Variable Copays can apply. For details visit https://welcometouhc.com/csac or call 1-800-445-9090.	California residents: Not covered. Nevada residents: variable Copays can apply. For details visit https://welcometouhc.com/csac or call 1-800-445-9090.
Orthodontia Benefit (dental braces for children and adults)	50% of the discounted network amount after Deductible met. Lifetime orthodontia max: \$2,000/person.	50% of the <u>non-discounted</u> Allowed charge after Deductible met.	50% to a lifetime maximum orthodontia benefit of \$2,000 per person.	\$1,500 Copay.	California residents: Not covered. Nevada residents: Plan pays up to a lifetime maximum orthodontia benefit of \$1,500/person.

* For the DPPO Plan in Texas: no cost-sharing, benefit covered in full, Deductible does not apply.

What is Not Covered (Excluded) Under the Dental Plan Options

Each Dental Plan has certain **limitations** on how often a certain dental service is payable by that Dental Plan. For example, a dental prophylaxis (teeth cleaning) is generally payable once per 6 months. Contact your Dental Plan for details on limitations for that Plan's dental services.

Each Dental Plan has certain **exclusions** that are services not covered by the Dental Plan. Contact the Dental Plan for more details on what is covered and not covered. The following are exclusions common to all the Dental Plan Options:

- a. Dental services that are not necessary.
- b. Any service done for Cosmetic purposes that is not listed as a covered Cosmetic service by the Dental Plan.
- c. Any Dental Procedure not directly associated with dental disease.
- d. Services related to the Temporomandibular Joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone Surgery (including that related to the Temporomandibular Joint). No coverage is provided for orthognathic Surgery, jaw alignment, or treatment for the Temporomandibular Joint.
- e. Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
- f. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
- g. Orthodontia treatment in progress prior to the effective date of Dental plan coverage.
- h. Extractions required for orthodontic purposes.

How To File A Claim For Benefits Under The UnitedHealthcare Dental Plans

Providers in the UnitedHealthcare Dental Network

There is no need to file a claim if you obtain services and supplies from a UnitedHealthcare dental network provider. Refer to "Dental Network" section earlier in this Chapter for information on how to schedule an appointment.

Providers Not in the UnitedHealthcare Dental Network (when an out-of-network provider is used)

If you use a non-network (out-of-network) provider for covered dental services and supplies, follow these procedures for reimbursement:

- A completed claim form is not required as long as you submit an itemized bill from the dental provider. The itemized bill must include the patient's name and age (DOB), address, identification number, name and address of the provider of services, date of service, list of services and/or items received and the charge for each.
- Write the member's (Carpenter's) Social Security Number on the bill.

- Bills for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement.
- Mail the itemized bill to:

UnitedHealthcare Dental
Attn: Claims Department
P.O. Box 30963
Salt Lake City, UT 84130-0963

Deadline for Claim Submission

You should submit your claim **within 90 days** from the date on which covered expenses were first incurred. Failure to file your claim within 90 days will not invalidate or reduce your claim, if it was not reasonably possible to file the claim within that time. However, in that case the claim must be submitted as soon as reasonably possible and **in no event later than 1 year after the date on which the charges were incurred.**

If the claim is submitted more than 1 year after the date on which the charges were incurred, it will be denied.

If you receive an adverse benefit determination, the notice will explain the process to appeal a claim.

Questions About A Dental Plan

If you have any questions about submitting your claim, or have questions about a Dental Plan, contact UnitedHealthcare Dental at the phone numbers listed on the Quick Reference Chart in the front of this document.

Chapter 8: VISION PLAN

This Chapter includes information on:

- Overview of Vision Plan services
- A Schedule of Vision Benefits
- Vision Plan limitations and exclusions
- How to File a Vision Claim

The Vision Plan benefit (provided through UnitedHealthcare) is available to Eligible Individuals enrolled in an HMO Medical Plan, or the Anthem Medical PPO Plan.

The insured UnitedHealthcare Vision Plan benefit is considered an excepted benefit under the Affordable Care Act.

The information in this Chapter is a summary of your insured Vision Plan coverage. Further details on the coverage are found in the benefit material issued by UnitedHealthcare Vision. Where the information in this Chapter deviates from the certificate of coverage and summary of benefits produced by the insurance company, the insurance company documents will prevail.

If you need a copy of the Vision Plan benefit material, contact the Administrative Office.

What Is The Vision Plan Benefit?

The Vision Plan is designed to cover visual needs (rather than Cosmetic materials) by providing coverage for standard vision examinations and eyewear materials such as eyeglasses or contact lenses. Vision benefits are administered by an independent Vision Plan insurance company, whose name and address are listed on the Quick Reference Chart in the front of this document.

Not every vision care service or supply is covered by the Vision Plan, even if prescribed, recommended, or approved by your Physician or optical provider. The Plan covers only those services and supplies that are Medically Necessary and included as a covered benefit. The Plan will not reimburse any expenses that are not eligible vision expenses. That means you will be responsible for paying the full cost of all expenses that are determined to be medically unnecessary, determined to be in excess of the Allowed Charges, not covered by the Vision Plan, or are in excess of a maximum Vision Plan benefit.

The Anthem Medical PPO Plan Deductible and Anthem Medical PPO Plan Out-of-Pocket Limit does not apply to (or accumulate) Vision Plan benefits.

The Vision Plan includes a **network of vision providers** who extend a discount to you for covered vision services. Covered vision expenses are noted in the Schedule of Vision Benefits in this Chapter and refer to the Allowed Charge for covered services up to the maximum allowed as payable under this Vision Plan.

The Vision Plan coverage will pay 100% of Allowable Charges after the applicable Copayment when an Eligible Individual receives covered services and supplies from a UnitedHealthcare network vision provider (See the Schedule of Vision Benefits for more information on vision benefits.)

Schedule Of Vision Benefits
This chart shows what the Plan pays.

Covered Vision Benefits	Explanations and Limitations (See also the Vision Plan Exclusions section.)	Plan Pays	
		Network Provider	Non-Network Provider (reimbursement for material only, no coverage for fitting/evaluation services)
Vision Examination	<ul style="list-style-type: none"> One eye examination for glasses or contact lenses is payable once each 12 months. 	100% after a \$10 Copay per exam.	You pay 100% and later submit your claim for reimbursement. No Copay. You will be reimbursed up to \$40 per exam.
Frames for Eyeglasses	<ul style="list-style-type: none"> One frame is payable once each 24 months. 	You pay a \$20 Copay for lenses only or lenses and a frame, to a maximum of \$130 allowance.	You pay 100% and later submit your claim for reimbursement. No Copay. You will be reimbursed up to \$65 per frame.
Lenses for Eyeglasses	<p>Plan covers lenses once each 12 months:</p> <ul style="list-style-type: none"> Scratch-resistant coating of lenses Polycarbonate lenses for adults and children Single vision lens are defined as one single power across their entire surface with single optical center and made from CR-39 or glass material. 	<p>You pay a \$20 Copay for any of these lenses: single vision, lined bifocal, lined trifocal, or lenticular.</p> <p>Only one Copay applies if you obtain a frame and lenses at the same time.</p>	<p>You pay 100% and later submit your claim for reimbursement. No Copay. You will be reimbursed for lenses up to:</p> <p>Single Vision: \$40. Lined Bifocals: \$60. Lined Trifocals: \$80. Lenticular: \$80.</p> <p>If only one lens is needed, the allowance will be one-half the pair allowance.</p>
Laser Vision Benefit		<p>If you use Laser Vision Network of America you can receive a 15% discount off usual and customary pricing, 5% off promotional pricing. Greater discounts available through set pricing at LasikPlus locations.</p> <p>Call 1-888-563-4497 for more information or visit www.uhclasik.com</p>	No discount available

Schedule Of Vision Benefits This chart shows what the Plan pays.			
Covered Vision Benefits	Explanations and Limitations (See also the Vision Plan Exclusions section.)	Plan Pays	
		Network Provider	Non-Network Provider (reimbursement for material only, no coverage for fitting/evaluation services)
Contact Lenses	<ul style="list-style-type: none"> Contact lenses are payable once each 12 months, in lieu of all other lens and frame benefits. Elective Contact Lenses: The fitting/evaluation fees, contact lenses and up to two follow-up visits are covered in full (after Copay). Necessary Contact Lenses: Covered in full after Copay. Contact lenses are necessary if the covered person has: aphakia; keratoconus; anisometropia; Irregular corneal/astigmatism; facial deformity; or corneal deformity. 	<p>Contact Lenses (Visually Necessary): 100% after a \$20 Copay</p> <p>Elective Lenses (not Visually Necessary): 100% after a \$20 Copay</p> <p>If you choose disposable contacts, up to 4 boxes are included when obtained from a network provider. A \$125 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside the covered selection (\$20 material Copay fee does not apply). This includes toric, gas permeable and bifocal contact lenses.</p> <p>Covered contact lens selection does not apply at Costco, Walmart or Sam's Club.</p>	<p>You pay 100% and later submit your claim for reimbursement. No Copay. You will be reimbursed up to:</p> <p>Contact Lenses (Visually Necessary): \$210 per pair or \$105 per lens.</p> <p>Elective Lenses (not Visually Necessary): \$125 per pair.</p>

How To Use The Vision Plan Benefit (Through UnitedHealthcare)

To locate a UnitedHealthcare network vision care provider, use the Provider Locator on **myuhcvision.com**, or call **1-800-638-3120**. You can use the search feature to search by name, office name or location. Once you have selected a network provider, call to schedule your appointment. Tell them you are a UnitedHealthcare vision plan member, give the primary insured's last name, patient's name and date of birth.

You don't need a member ID card to use your benefits. However, if you'd like one, you can print one from **myuhcvision.com**. Once you've logged in, click on "Print ID Card" from the main dashboard page.

If you obtain services from a provider who is not a UnitedHealthcare Vision network provider, refer to the section on claims at the end of this Chapter for information on how to file a claim for reimbursement.

What Is Not Covered (Excluded) Under The Vision Plan?

The Vision Plan excludes the following:

- a. Non-prescription items (e.g. Plano lenses).
- b. Services that the Covered Person, without cost, obtains from any governmental organization or program.
- c. Services for which the Covered Person may be compensated under Workers' Compensation Law, or other similar employer liability law.
- d. Any eye examination required by an employer as a condition of employment, by virtue of a labor agreement, a government body, or agency.
- e. Medical or surgical treatment for eye disease, which requires the services of a Physician.
- f. Replacement or repair of lenses and/or frames that have been lost or broken.
- g. Optional Lens Extras not listed in the Schedule(s) of Covered Vision Services.
- h. Missed appointment charges.
- i. Applicable sales tax charged on Services.
- j. Services that are not specifically covered by the Policy.
- k. Procedures that are considered to be Experimental, Investigational or Unproven. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
- l. Any Vision Service rendered by the Policyholder.
- m. Intraocular lenses.

How To File A Claim For Benefits Under The UnitedHealthcare Vision Plan

Providers in the UnitedHealthcare Vision Network

There is no need to file a claim if you obtain services and supplies from a UnitedHealthcare vision network provider. Refer to "How to Use the Vision Plan Benefit" earlier in this Chapter for information on how to schedule an appointment.

Providers Not in the UnitedHealthcare Vision Network

If you use a non-network (out-of-network) provider for covered vision services and supplies, you pay for the service and later can submit your claim for reimbursement following these procedures:

A completed claim form is not required as long as you submit an itemized bill from the provider. The itemized bill must include the patient's name, age and address, your identification number, name and address of the provider of the service, date of service, list of services and/or items received and the charge for each, a statement indicating that you are or you are not enrolled for coverage under any other vision insurance plan or program. If you are enrolled for other coverage you must include the name of the other insurance carrier(s). Write the member's (Carpenter's) Social Security number on the bill.

Bills for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement.

Mail the itemized bill to:

UnitedHealthcare Vision
Attn: Claims Department
P.O. Box 30978
Salt Lake City, UT 84130

Deadline for Claim Submission

You should submit your claim for vision services **within 90 days** from the date on which covered expenses were first incurred. Failure to file your claim within 90 days will not invalidate or reduce your claim, if it was not reasonably possible to file the claim within that time. However, in that case the claim must be submitted as soon as reasonably possible and in no event later than **1 year** after the date on which the charges were incurred.

If the claim is submitted more than 1 year after the date on which the charges were incurred, it will be denied.

If you receive an adverse benefit determination, the notice will explain the process to appeal a claim.

Questions About the Vision Plan

If you have any questions about submitting your claim or have questions about the Vision Plan, contact UnitedHealthcare Vision at the phone numbers listed on the Quick Reference Chart in the front of this document.

Chapter 9: COORDINATION OF BENEFITS (COB) AND THIRD PARTY RECOVERY

This Chapter includes information on:

- Coordination of Benefits (COB) General Rules
- Medicare and Coordination of Plan benefits
- Third Party Recovery
- Factors that could affect your receipt of benefits

Coordination Of Benefits (COB)

The information below applies to the Anthem Medical PPO Plan. COB is not performed for dental plan or vision plan benefits. If you are enrolled in an insured HMO Medical Plan offered by the Trust, see the benefit booklet and any other materials provided by that organization for information about how benefits are coordinated or what reimbursement obligations you have under your option.

Within the Southwest Carpenters Health Plan, please keep in mind that no individual can have dual coverage under any of the benefit options offered under the Plan. For example, a married couple both of whom are eligible as employees under the Plan cannot claim themselves as Dependents of each other and, if they have children, the children can only be covered as Dependents of one parent.

Plan benefits have been designed to help you meet the cost of Preventive Care, and treatment for disease or injury. Since it is not intended that you receive greater benefits than the actual Allowable Charges incurred, the Anthem Medical PPO Plan benefits will be coordinated with those provided to the Eligible Employee and their Dependents by any other group benefit or service plan.

These COB rules do not apply to the Prescription Drug Benefits under the Anthem Medical PPO Plan, or to Dental Plan or Vision Plan benefits.

Coordination Of Benefits (COB)

If you are covered by more than one group health plan, your benefits under This Plan (term defined below) will be coordinated with the benefits of those Other Plans (term defined below). These coordination provisions (shown below) apply separately to each member, per Calendar Year for medical plan benefits.

Definitions Related to COB

The meanings of key terms used in this COB section are shown below.

- **Allowable Expense** is any necessary, reasonable and customary item of expense which is at least partially covered by any plan covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

An expense that is not covered by any plan covering the person for whom a claim is made is not an Allowable Expense. The following are not Allowable Expenses:

- a. Use of a private Hospital room is not an Allowable Expense unless the patient's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practices, or one of the plans routinely provides coverage for Hospital private rooms.
 - b. If you are covered by two plans that calculate benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method, any amount in excess of the higher of the reasonable and customary amounts.
 - c. If a person is covered by two plans that provide benefits or services on the basis of negotiated rates or fees, an amount in excess of the lower of the negotiated rates.
 - d. If a person is covered by one plan (that calculates its benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method) and covered by another plan (provides its benefits or services on the basis of negotiated rates or fees), any amount in excess of the negotiated rate.
 - e. The amount of any benefit reduction by the Principal Plan because you did not comply with the Plan's provisions is not an Allowable Expense. Examples of these types of provisions include second surgical opinions, utilization review requirements, and network provider arrangements.
 - f. If you advise us that all plans covering you are high Deductible health plans as defined by Section 223 of the Internal Revenue Code, and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code, any amount that is subject to the primary High Deductible Health Plan's Deductible.
- **Other Plan** is any of the following:
 - a. Group, blanket or franchise insurance coverage;
 - b. Group service plan contract, group practice, group individual practice and other group prepayment coverages;
 - c. Group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.

The term "Other Plan" refers separately to each agreement, policy, contract, or other arrangement for services and benefits, and only to that portion of such agreement, policy, contract, or arrangement which reserves the right to take the services or benefits of other plans into consideration in determining benefits.

- **Principal Plan** is the plan which will have its benefits determined first.
- **This Plan** (as used in this chapter) is that portion of the Anthem Medical PPO plan which provides benefits subject to this COB provision.

Effect On Benefits

- a. If This Plan is the Principal Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.
- b. If This Plan is not the Principal Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed Allowable Expense.

- c. If the Principal Plan for a family member is an HMO plan, This Plan will pay for Out-of-Pocket expenses such as Copayments, Deductibles and other services not available through the HMO provider.
- d. If the Principal Plan for a family member is an HMO plan but the family member is treated by a non-HMO provider when those services are available through the HMO provider, This Plan will not make any payment as secondary payer.
- e. The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if you were covered under This Plan only.

Order Of Benefits Determination

The first of the following rules which applies will determine **the order in which benefits are payable**:

- 1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision. This includes Medicare in all cases, except when the law requires that This Plan pays before Medicare.
- 2. A plan which covers you as an employee pays before a plan which covers you as a Dependent. But, if you are a Medicare beneficiary and also a Dependent of an employee with current employment status under another plan, this rule might change. If, according to Medicare's rules, Medicare pays after that plan which covers you as a Dependent, then the plan which covers you as a Dependent pays before the plan which covers you as an employee.
For example: You are covered as a retired employee under this plan and entitled to Medicare (Medicare would normally pay first). You are also covered as a Dependent of an active employee under another plan (in which case Medicare would pay second). In this situation, the plan which covers you as a Dependent will pay first, Medicare will pay second, and the plan which covers you as a retired employee would pay last.
- 3. For a Dependent child covered under plans of two parents, the plan of the parent whose birthday falls earlier in the Calendar Year pays before the plan of the parent whose birthday falls later in the Calendar Year. However, if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits.

Exception to rule 3: For a Dependent child of parents who are divorced or separated, the following rules will be used in place of Rule 3:

- a. If the parent with custody of that child for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that child as a Dependent pays first.
- b. If the parent with custody of that child for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:
 - i. The plan which covers that child as a Dependent of the parent with custody.
 - ii. The plan which covers that child as a Dependent of the stepparent (married to the parent with custody).
 - iii. The plan which covers that child as a Dependent of the parent without custody.
 - iv. The plan which covers that child as a Dependent of the stepparent (married to the parent without custody).
- c. Regardless of a and b above, if there is a court decree which establishes a parent's financial responsibility for that child's health care coverage, a plan which covers that child as a Dependent of that parent pays first.

4. The plan covering you as a laid-off or retired employee or as a Dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the Dependent of such a person. But, if either plan does not have a provision regarding laid-off or retired employee, provision 6 applies.
5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an employee, a Dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan do not agree under these circumstances with the Order of Benefit Determination provisions of This Plan, this rule will not apply.
6. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest pays first unless two of the plans have the same effective date. In this case, Allowable Expense is split equally between the two plans.

In no event will you be entitled to benefits from this Plan in excess of those which you would have received if no Other Plan benefits were available.

Medicare And Plan Benefits

If you are an active member and covered by Medicare, the Anthem Medical PPO Plan will generally pay benefits first. Medicare may provide backup coverage for some care if Anthem Medical PPO Plan benefits do not pay the full cost. In technical terms, the Anthem Medical PPO Plan is “primary” for your covered Hospital and medical expenses and Medicare is “secondary.” You have, however, as required by government regulations, the option to reject the Plan as primary provider for your Hospital and medical coverage. If you want more information, please contact the Administrative Office.

How to Enroll in Medicare

If you are approaching age 65, you are not automatically enrolled in Medicare (unless you have filed an application and established eligibility for a monthly Social Security benefit). If you have not applied for Social Security benefits, you must file a Medicare application form during the 3-month period prior to the month in which you become 65 years of age in order for coverage to begin at the start of the month in which you reach age 65. Call or write your nearest Social Security office 90 days prior to your 65th birthday and ask for an application for Medicare.

Coordination of Benefits with Medicare

Coverage Under Medicare and This Plan for End-Stage Renal Disease: If, while actively employed, an Eligible Individual under this Plan becomes entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and **Medicare pays second for 30 months** starting the **earlier** of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second. See also the Dialysis row in the Schedule of Medical Benefits in this document.

Summary Chart on Coordination of Benefits (COB) with Medicare: If you are covered by Medicare and also have other group health plan coverage, the coordination of benefits (COB) rules are set by the Centers for Medicare & Medicaid Services (CMS). These COB rules are outlined below:

Summary of the Coordination of Benefits between Medicare and Another Payor			
If you:	Situation	Pays First	Pays Second
Are covered by both Medicare and Medicaid	Entitled to Medicare and Medicaid	Medicare	Medicaid, but only after other coverage such as a group health plan has paid
Are age 65 and older and covered by a group health plan because you are working or are covered by a group health plan of a working Spouse of any age	The employer has less than 20 employees*	Medicare	Group health plan
	The employer has 20 or more employees	Group health plan	Medicare
Have an employer group health plan after you retire and are age 65 or older	Entitled to Medicare	Medicare	Group health plan (e.g. a retiree plan coverage)
Are disabled and covered by a large group health plan from your work or from a family member who is working	The employer has less than 100 employees**	Medicare	Group health plan
	You are entitled to Medicare or the Employer has 100 or more employees	Group health plan	Medicare
Have End-Stage Renal Disease (ESRD is permanent kidney failure requiring dialysis or a kidney transplant) and group health plan coverage (including a retirement plan)	First 30 months of eligibility or entitlement to Medicare	Group health plan	Medicare
	After 30 months of eligibility or entitlement to Medicare	Medicare	Group health plan
Are covered under workers' compensation because of a job-related injury or illness	Entitled to Medicare	Workers' compensation for worker's compensation-related claims	Usually does not apply however Medicare may make a conditional payment.
Have black lung disease and are covered under the Federal Black Lung Benefits Program	Entitled to Medicare and the Federal Black Lung Benefits Program	Federal Black Lung Benefits Program for black lung-related claims	Medicare
Have been in an accident where no-fault or liability insurance is involved	Entitled to Medicare	No-fault or Liability insurance, for the accident-related claims	Medicare

Summary of the Coordination of Benefits between Medicare and Another Payor			
If you:	Situation	Pays First	Pays Second
Are a veteran and have Veterans' benefits	Entitled to Medicare and Veterans' benefits	Medicare pays for Medicare-covered services. Veterans' Affairs pays for VA-authorized services. Generally, Medicare and VA cannot pay for the same service.	Usually does not apply
Are covered under TRICARE	Entitled to Medicare and TRICARE	Medicare pays for Medicare-covered services. TRICARE pays for services from a military Hospital or any other federal provider.	TRICARE may pay second
Are age 65 or over <u>OR</u> , are disabled and covered by both Medicare and COBRA	Entitled to Medicare	Medicare	COBRA
Have End-Stage Renal Disease (ESRD) and COBRA	First 30 months of eligibility or entitlement to Medicare	COBRA	Medicare
	After 30 months	Medicare	COBRA
See also: https://www.medicare.gov/Pubs/pdf/02179-medicare-coordination-benefits-payer.pdf or 1-800-Medicare for more information.			

Subrogation and Reimbursement

These provisions apply when the Plan pays benefits as a result of injuries or illnesses you sustained and you have a right to a recovery or have received a recovery from any source.

Recovery

A “recovery” includes, but is not limited to, monies received from any person or party, any person’s or party’s liability insurance, uninsured/underinsured motorist proceeds, Workers’ Compensation insurance or fund, “no-fault” insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements characterize the money you receive as a recovery, it shall be subject to these provisions.

Subrogation

The Plan has the right to recover payments it makes on your behalf from any party responsible for compensating you for your illnesses or injuries. The following apply:

- The Plan has first priority from any recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- You and your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.

- In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.
- To the extent that the total assets from which a recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by you, the Plan's subrogation claim shall be first satisfied before any part of a recovery is applied to your claim, your attorney fees, other expenses or costs.
- The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs you incur. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement

If you obtain a recovery and the Plan has not been repaid for the benefits the Plan paid on your behalf, the Plan shall have a right to be repaid from the recovery in the amount of the benefits paid on your behalf and the following provisions will apply:

- You must promptly reimburse the Plan from any recovery to the extent of benefits the Plan paid on your behalf regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of your recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any recovery. Further, the Plan's rights will not be reduced due to your negligence.
- You and your legal representative must hold in trust for the Plan the proceeds of the gross recovery (i.e., the total amount of your recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon your receipt of the recovery. You and your legal representative acknowledge that the portion of the recovery to which the Plan's equitable lien applies is a Plan asset.
- Any recovery you obtain must not be dissipated or disbursed until such time as the Plan has been repaid in accordance with these provisions.
- You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.
- If you fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your recovery whichever is less, from any future benefit under the Plan if:
 1. The amount the Plan paid on your behalf is not repaid or otherwise recovered by the Plan; or
 2. You fail to cooperate.
- In the event that you fail to disclose the amount of your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.

- The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of your recovery, whichever is less, directly from the providers to whom the Plan has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and the Plan will not have any obligation to pay the provider or reimburse you.
- The Plan is entitled to reimbursement from any recovery, in first priority, even if the recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or make you whole.

Your Duties

- You must promptly notify the Plan of how, when and where an accident or incident resulting in personal injury or illness to you occurred, all information regarding the parties involved and any other information requested by the Plan.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- You must not do anything to prejudice the Plan's rights.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf.
- You must immediately notify the Plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

The Plan Sponsor has sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this Plan in its entirety and reserves the right to make changes as it deems necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any recovery because of injuries sustained by the covered person, that recovery shall be subject to this provision.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision. The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal injury protection policy regardless of any election made by you to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

<h3>Factors That Could Affect Your Receipt Of Benefits</h3>
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Many of the points below specifically reference the Anthem Medical PPO Plan. If you are enrolled in another option(s) such as an HMO, see the benefit booklet and any other materials provided by that insurance company for information about factors that might affect your receipt of benefits.

Certain factors could interfere with payment of benefits from the Plan (result in your

disqualification or ineligibility, denial of your claim, or loss, forfeiture or suspension of benefits you might reasonably expect). Examples of such factors include the following:

- **Failure to submit properly completed enrollment forms.** The effective date of your health coverage is contingent upon the date the Administrative Office receives properly completed enrollment forms. See “Enrollment” in Chapter 3.
- **Performance of work outside the coverage of a Collective Bargaining Agreement or allowance of under-reporting of Hours Worked.** All hours credited to your reserve account, which could otherwise be used to establish eligibility, will be cancelled if you knowingly perform work of the type covered by any Collective Bargaining Agreement outside the coverage of a Collective Bargaining Agreement while knowing that work covered by a Collective Bargaining Agreement is available or if you knowingly allow a Contributing Employer to under-report or over-report Hours Worked by you. See Chapter 3 for more information.
- **Failure to report other health coverage.** All hours credited to your reserve account, which could otherwise be used to establish your eligibility, will be cancelled if you fail to report to the Administrative Office the existence of other health coverage(s) to which you or your Dependents are entitled. You must report this information whenever a claim form is submitted to Anthem.
- **Failure to follow the Plan’s provisions for preauthorization.** If you are enrolled in the Anthem Medical PPO Plan and you wish to receive the maximum benefits available, you must comply with that Plan’s preauthorization requirements for certain medical plan expenses and certain Prescription Drugs. See “Preauthorization” in Chapter 4 for more information.
- **Failure to use contracting providers.** If you are enrolled in a PPO medical, Prescription Drug, dental or vision plan, you will not receive the highest level of coverage available for many services unless you use contracting (“PPO,” “participating,” “network,” “direct contract”) providers. See Chapters 4 and 5 for more information.
- **Failure to pay premiums or comply with notification requirements for COBRA continuation coverage.** Loss of COBRA continuation coverage may result from failure to pay the full amount of premiums in a timely manner or failure by you or a beneficiary to provide the Administrative Office with notice of a Qualifying Event within the time limits set forth in “COBRA Continuation Coverage” in Chapter 3 of this booklet.
- **Failure to submit claims in a timely manner.** You should submit all Anthem Medical PPO Plan health care claims and appeals and required information **within the time frames described in “Claim Filing and Claim Appeals” Chapter 15.**
- **The Plan’s provisions for coordination of health care benefits.** If you or a Dependent have medical, vision, or dental coverage under another plan, payment of benefits under the Anthem Medical PPO Plan will be coordinated with payment of benefits by that other plan. See “Coordination of Benefits and Third Party Recovery” in Chapter 9 for more information.
- **The Plan’s provisions regarding payment from another source.** The Trust may refuse to pay benefits if you fail to fulfill your reimbursement obligation regarding benefits for which another source makes payment including signing agreements to this effect in the form required by the Administrative Office. The Trust will not pay benefits if it determines that a third party has already made payment. It reserves the right to withhold benefit payments under the Plan if it is not satisfied that proceeds resulting from the liability of a third party will be available

to reimburse the Plan. See “Coordination of Benefits (COB) and Third Party Recovery” in Chapter 9.

- **Failure to update your address, phone number, email address or beneficiary designation.** If you move or change your phone number or email address, it is your responsibility to keep the Administrative Office informed about the change so they can reach you. Otherwise, you may not receive important information about your benefits. In addition, you must contact the Administrative Office regarding any changes in your family status (such as marriage, divorce, birth, death or child reaches age 26 years).

To report a change, use the enrollment form available at the Administrative Office or on the Trust Fund’s website.

You will be held liable for benefit payments/premiums based on incorrect information about family members (for example, if you fail to notify the Administrative Office that you have divorced or a child has ceased to be an eligible Dependent). In addition, you may be liable for other costs incurred by the Trust as a result of the incorrect information. These costs include (but are not limited to) attorneys’ fees, administrative costs, and reasonable interest.

Any factors affecting your receipt of benefits will depend on your particular situation. If you have questions, contact the Administrative Office at (213) 386-8590 or (800) 293-1370. See also Chapter 3 for information on maintaining eligibility for benefits.

Chapter 10: LONG TERM MONTHLY DISABILITY BENEFITS

This Chapter includes information on:

- Special terms applicable to this LTD benefit
- Who is eligible for LTD benefits
- What is the LTD benefit
- When do LTD benefits begin and end
- Comparing the LTD benefit to an early retirement pension with supplemental LTD benefit
- How to apply for LTD benefits

The information in this Chapter only applies to individuals who meet the special definition of Eligible Individual for **Long Term Monthly Disability Benefit** purposes, as described below.

Special Terms Applicable To This LTD Benefit

The following terms used in this Chapter have the meaning assigned to them in the Southwest Carpenters Pension Plan. Refer to the separate Pension Plan benefit booklet for the definition of these terms or contact the Administrative Office.

<ul style="list-style-type: none">• Pension Credit• Permanent Break in Service• Hours Worked in Covered Employment• Contribution Date• Future Service Credit• Covered Employment	<ul style="list-style-type: none">• Non-covered Employment• Vested Pension• Annuity Starting Date• Pension• Qualified Surviving Spouse Pension
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Who Is Eligible For LTD Benefits?

Individuals who meet all of the following requirements are eligible for Long Term Monthly Disability Benefits (**also referred to as “LTD” benefits**) including Supplemental Benefits and Auxiliary Disability Benefits.

An individual who:

- Is Totally Disabled (see the Glossary Chapter for the definition), and
- Has accumulated at least 5 Pension Credits under the Southwest Carpenters Pension Plan without a Permanent Break in Service, and
- Has, under the Southwest Carpenters Pension Plan, 500 Hours Worked in Covered Employment since their Contribution Date and who has, under the Southwest Carpenters Pension Plan either:

- a. Completed at least 350 Hours Worked in Covered Employment within the 12-month period immediately preceding the date of Total Disability (refer to the Glossary for the definition of Total Disability), or
 - b. Completed sufficient Hours Worked in Covered Employment to earn at least three-twelfths (which is $\frac{1}{4}$) of Future Service Credit in each of three Calendar Years in the five consecutive Calendar Year period ended immediately prior to the Calendar Year in which the individual became Totally Disabled, and
- Has not worked in Non-Covered Employment after November 1, 1992, or who returned to Covered Employment after working in Non-Covered Employment and worked in such Covered Employment for at least as long as the period of Non-Covered Employment, and
 - Has not established an Annuity Starting Date for a Pension under the Southwest Carpenters Pension Plan, with the following exception:

Exception - An individual receiving an Early Retirement Pension under the Southwest Carpenters Pension Plan is eligible for Long Term Monthly Disability Benefits if the individual was granted a Social Security disability award effective **within 12 months** of the date the Administrative Office received their completed Early Retirement Pension application.

The individual must apply for Long Term Monthly Disability Benefits within 90 days following the date of the Social Security disability award. Contact the Administrative Office for the necessary application form.

What Is The LTD Benefit?

In General

The LTD benefit is partial income replacement to you (an Eligible Individual) when you cannot work for a long period of time due to your accident or illness (whether work-related or not).

The LTD benefits provides a monthly amount of money during disability and continues through the earlier of normal retirement age or commencement of a pension under the Southwest Carpenters Pension Plan, (that is calculated based upon vested pension credits earned under the Pension Plan and which differs depending on marital status and other factors).

The monthly benefit differs depending on whether the Eligible Individual is married.

- For LTD Eligible Individuals who **are not married**, the Long Term Monthly Disability Benefit is the monthly amount of a Normal Pension that would be payable to the individual at age 65.
- For LTD Eligible Individuals who **are married** as of the date Long Term Monthly Disability Benefits begin, the monthly benefit is reduced by multiplying the Normal Pension monthly benefit at age 65 by 78% minus .4% for each year the individual's Spouse is younger than the LTD Eligible Individual or plus .4% for each year the individual's Spouse is older than the LTD Eligible Individual.

Supplemental Benefit

If the LTD Eligible Individual is receiving an Early Retirement Pension and qualifies for Long Term Monthly Disability Benefits because the Individual falls under the exception described at the end of the section "Who is Eligible for LTD Benefits?" above, that Individual's Long Term Monthly Disability Benefit will be the difference (if any) between the monthly amount calculated in accordance with the above paragraph and the monthly amount of the Early Retirement Pension (determined in the case of a married individual, as being in the Qualified Surviving Spouse Pension form).

When Do LTD Benefits Begin?

Generally, payment of Long Term Monthly Disability Benefits will begin with the later of the sixth (6th) month of Total Disability or the first (1st) month following the date the Administrative Office receives the Eligible Individual's completed application for benefits including any required documentation.

Subject to proper and timely application, Long Term Monthly Disability Benefits for individuals qualifying for a Supplemental Benefit described above will begin with the later of the date Social Security disability benefits begin or the Annuity Starting Date of the Early Retirement Pension. If any retroactive payment is due, it will be paid in one lump sum without interest.

Please contact the Pension Department at the Administrative Office for your pension options to determine if an Early Retirement Pension is an option for you, or is your best option.

Auxiliary Disability Benefit

If an LTD Eligible Individual's Long Term Monthly Disability Benefits begin later than the sixth (6th) month of the Individual's Total Disability but within two (2) years after the date of a Social Security disability award notice, the Individual will be entitled to payment equal to what would have been paid from the date Social Security disability benefits began to the date Long Term Monthly Disability Benefits begin (less any Early Retirement Pension payments made during such period). If any retroactive payment is due, it will be paid in one lump sum without interest.

When Do LTD Benefits End?

Long Term Monthly Disability Benefits **will cease immediately** upon the occurrence of any of the following events:

- The Eligible Individual ceases to be Totally Disabled or fails to provide the Administrative Office with sufficient evidence of continued Total Disability within 30 days of its request. In the event the Eligible Individual becomes engaged in trial work under a Social Security program, payment of Long Term Monthly Disability Benefits may continue for a period of up to nine months, provided the Eligible Individual retains their entitlement to a Social Security disability benefit throughout the trial work period.
- **Eligible Individuals must notify the Administrative Office in writing of their recovery from Total Disability or discontinuance of Social Security disability benefits within 15 days of such event. Failure to do so will result in delay of commencement of Pensions by the Southwest Carpenters Pension Plan.**
- Attainment of Normal Retirement Age under the Southwest Carpenters Pension Plan
- Attainment of the conditions for qualification for an unreduced Pension under the Southwest Carpenters Pension Plan

- Establishment of an Annuity Starting Date for a Pension under the Southwest Carpenters Pension Plan except as provided above, at the end of the section “Who is Eligible?” in this Chapter
- Performance of gainful employment
- Death of an Eligible Individual.

Comparison Of LTD Benefits To The Early Retirement Pension With Supplemental LTD

For married participants, the benefit payable as an Early Retirement Pension may be greater than the LTD benefit payable from the Health and Welfare Plan because the calculation of a LTD benefit uses more severe reduction factors for disabled, married participants than for unmarried participants. These reduction factors can be avoided by electing an Early Retirement Pension in the form of a single life annuity.

However, the Carpenter must have a minimum of 10 Pension Credits and attainment of age 55 to qualify for an Early Retirement Pension, whereas the LTD benefit only requires a minimum of 5 Pension Credits and there is no minimum age requirement.

Please contact the Pension Department at the Administrative Office for your pension options to determine if an Early Retirement Pension is an option for you, or is your best option.

The following example illustrates the difference in amount for a hypothetical disabled Carpenter who is married:

Assume that the disabled Carpenter has accrued a \$1,000 benefit payable at Normal Retirement Age (NRA) under the Pension Plan. The Carpenter’s LTD benefit under the Health and Welfare Plan is reduced by the Husband-and-Wife reduction factors for disabled participants (78% plus or minus .4%). If the Carpenter and Spouse are both age 57, the amount of the monthly LTD benefit would be \$780 ($\$1,000 \times 78\%$).

On the other hand, if the same participant elects the Early Retirement Pension paid as a 50% Qualified Surviving Spouse Pension, the \$1,000 benefit would be reduced first for early retirement and second for payment in form of a Qualified Surviving Spouse Pension in the following manner: Age reduction for age 57 = 85%. $\$1,000 \times 85\% = \850 . Qualified Surviving Spouse Pension reduction = 88%. $\$850 \times 88\% = \748 .

In the foregoing example, the LTD benefit is larger (\$780) than the Early Retirement Benefit (\$748) if the Carpenter elects the 50% Qualified Surviving Spouse Pension. However, the disabled Carpenter could elect to take the Early Retirement Benefit in the form of a Single Life Annuity in which case the benefit would be \$850.

Please note: Because the reduction for early retirement starts at age 65 rather than age 62 for benefits accrued after 2010, the amount in the foregoing example would be less if any of the benefits were earned after 2010. Thus, if all of the benefits were earned after 2010, the \$1,000 monthly Early Retirement Pension for the couple aged 57 would first be reduced by 24% (1/4% per month for the eight years from age 65 to age 57) to \$760 ($\$1,000 \times 76\%$). That amount would be further reduced by 12% for payment in the form of a 50% Qualified Surviving Spouse Pension. $\$760 \times 88\% = \668.80 .

In addition to receiving the Early Retirement Pension, a disabled Carpenter participant may receive

Supplemental LTD benefits from the Health and Welfare Plan. The amount of the Supplemental LTD benefits is calculated as the difference between (1) the monthly LTD benefit minus (2) the monthly amount of the Early Retirement Pension. The amounts in (1) and (2) are calculated by applying the Qualified Surviving Spouse reduction factors for disabled participants (78% plus or minus .4%) in the case of a married Carpenter.

Thus, the member in the example above could receive a Supplemental LTD benefit of \$32 calculated as the difference between the LTD benefit (\$780) and the Early Retirement Pension (\$748). The combination of the \$32 Supplemental LTD benefit and the \$850 Early Retirement Pension would result in a total benefit of \$882 per month. Payment of the \$32 Supplemental LTD benefit ends upon attainment of Normal Retirement Age (NRA).

Some Questions And Answers To Consider About LTD Benefits

Will the LTD benefit continue to be payable to the surviving Spouse after the death of the Eligible Individual?

No. There is no survivor benefit payable to the Spouse after the participant dies. However, the surviving Spouse will be paid a Pre-Retirement survivor annuity from the Pension Plan if the Spouse and participant were married for at least one year and met the service requirements for a pension benefit at the time of death.

Will the LTD benefit be increased if the Spouse dies before the participant?

No. The pop-up feature is not available if the LTD benefit is elected. The pop-up feature is only available if the disabled participant elects an Early Retirement Pension in the form of a Qualified Surviving Spouse Pension.

After the LTD benefit ends, what form of pension is available under the Pension Plan?

After a participant reaches Normal Retirement Age, the LTD benefit under the Health and Welfare Plan terminates and a pension benefit may commence in any of the options available. A married participant may choose a Single Life Annuity or a Qualified Surviving Spouse Pension.

May a disabled Carpenter receive Partial or Pro-Rata LTD benefits?

Yes. Partial or Pro-Rata disability benefits are available from the Health and Welfare Plan if the applicable conditions of Article XI of the Pension Plan are satisfied.

Are LTD benefits subject to division following divorce?

Yes. The Plan will follow the terms of a qualified domestic relations order that awards part of the LTD benefit to the ex-Spouse.

How To File An Application (A Claim) For LTD Benefits/Proof Of Disability

An application for Long Term Monthly Disability Benefits can be obtained from the Administrative Office by calling (213) 386-8590 or toll-free (800) 293-1370.

Send the completed application form along with all requested documentation to:

Southwest Carpenters Health and Welfare Trust
Attn: Long Term Disability Dept.
533 S. Fremont Ave.
Los Angeles, CA 90071
(213) 386-8590 or (800) 293-1370

New LTD claims must include proof of your Total Disability, as outlined under “Initial Proof of Total Disability” below.

Initial Proof of Total Disability

The Plan accepts either of the following as proof of your Total Disability (see the Glossary Chapter for the definition of this term) when you first apply for LTD benefits:

- A Disability Award from the Social Security Administration (SSA). Applying for a Social Security Disability Award is free. See the SSA application at the following website: <https://www.ssa.gov/planners/disability/>.
- A written opinion by an Independent Review Organization (IRO) that is accredited by the Utilization Review Accreditation Commission (URAC). Contact the Administrative Office about the steps you need to take to have your medical records reviewed by an IRO to confirm that the IRO concurs with your Physician (MD, DO, or DPM) that you are Totally Disabled. You pay \$200 for the IRO review, and the Trust Fund pays the balance of the IRO’s review cost.

Neither the Plan nor the Administrative Office will make a determination of disability. Instead, the determination is made by Social Security or a URAC-accredited IRO.

The Administrative Office verifies that you’re eligible to apply for LTD benefits and that you have submitted initial proof of your disability that is acceptable in accordance with the Plan’s rules.

Continuing Proof of Total Disability

If you are receiving LTD benefits from the Plan, you must provide the Plan with proof of your continuing Total Disability on an annual basis. Each year, the Administrative Office will send you a letter requesting:

- Proof of your continuing Social Security Disability Income benefits, or
- A completed Physician Attestation of Continuing Disability form (if no Social Security Award), certifying that you remain Totally Disabled (as defined by the Plan).

As long as you provide proof of your continuing disability in a timely manner, your LTD benefits continue. If you do not provide timely proof of your disability, your LTD benefits end (benefits can be reinstated once the Plan receives proof of your continuing Total Disability). If your LTD benefits end, you receive an initial denial (an adverse benefit determination) letter (see Chapter 15 for information on how to file a claim appeal).

Deadline for Submission of an LTD Claim

Early retirement pensioners must submit their application (including a copy of their Social Security disability award) for Supplemental Long Term Monthly Disability Benefits to the Administrative Office **within 90 days of the date of their Social Security disability award.**

Notice of Approval or Denial of an LTD Claim

Following are the notices you may receive when you submit an LTD claim (see Chapter 15 for the procedure on filing claims for LTD benefits):

- Based on the Administrative Office's receipt of your Social Security Award or IRO confirmation of Total Disability, as well as your eligibility for LTD benefits under the Plan, the Administrative Office will notify you in writing whether your request for LTD benefits is approved or denied (an adverse benefit determination). You will receive the notice within 45 days of the date the Administrative Office receives the Social Security Award or IRO confirmation.
- You will be notified if you do not follow the Plan's procedures (for example, you do not submit the initial proof of disability). You then have 45 days in which to obtain the additional information.
- The 45-day period can be extended for up to 30 calendar days, provided the Administrative Office determines that an extension is necessary due to matters beyond its control and notifies you in writing (or electronically, as applicable) prior to the expiration of the initial 45-day period. The notification will indicate that additional time is needed to process the claim, the special circumstances for the extension, and the date by which the Administrative Office expects to provide its determination.

If, prior to the end of the first 30-day extension, the Administrative Office determines that due to matters beyond its control it cannot provide a notification within the first 30-day extension period, the determination period may be extended for up to an additional 30 calendar days. You will be notified prior to the first 30-day extension period of the circumstances that require the second extension, as well as the date by which the Administrative Office expects to provide a notification.

The notice of extension will explain the:

- a. Standards on which entitlement to a benefit is based,
 - b. Unresolved issues that are preventing a decision, and
 - c. Additional information that is needed to resolve those issues.
- If the Administrative Office needs additional information from you to make its decision, you will have at least 45 calendar days to submit the additional information. If a time period is extended because you fail to submit information, the time period will be measured from the date on which the notice of extension is sent until the date on which you respond, or until the day on which 60 days have elapsed since the date the notice was sent (whichever is earlier).

Questions About the LTD Benefits

If you have any questions about submitting your claim, or have questions about the LTD benefits, contact the Administrative Office at the phone numbers listed on the Quick Reference Chart in the front of this document.

For information on what to do if you disagree with the decision made in regard to your disability claim, see Chapter 15.

Chapter 11: EMPLOYEE LIFE INSURANCE SUMMARY

This Chapter includes information on:

- What is the life insurance benefit
- Your beneficiary for Life Insurance benefits
- How to continue your life insurance if you lose eligibility
- Information on filing life insurance claims

The information in this Chapter applies only to **Active Carpenters and Special Class Employees** who are Eligible Individuals at the time of their death (and it applies regardless of which medical benefit Option under the Plan covers them). COBRA participants are NOT covered by this benefit.

The information in this Chapter is a brief summary of your life insurance coverage. Further details on the coverage are found in the Certificate of Coverage issued by the Life Insurance Company listed on the Quick Reference Chart at the front of this document. If you need a copy of the Certificate, contact the Administrative Office or visit the Trust's website at www.carpenterssw.org.

What Are The Life Insurance Benefits?

EMPLOYEE LIFE INSURANCE BENEFIT	AMOUNT OF LIFE INSURANCE BENEFIT
In the event of your death from any cause while you are an Eligible Individual, a life insurance benefit will be paid to the beneficiary(ies) listed on your most recently signed life insurance beneficiary card/form on file at the Administrative Office.	\$20,000 of group term life insurance

Your Beneficiary For Life Insurance Benefits

Be certain that you have completed a life insurance beneficiary card/form and have submitted it to the Administrative Office. You may name any person or persons as the **beneficiary of your life insurance**. If you name more than one beneficiary, they will share equally unless you have designated otherwise. The interests of a beneficiary who dies before you will accrue to the surviving beneficiaries.

You may request a change of beneficiary at any time by submitting a new beneficiary card/form to the Administrative Office. Beneficiary cards/forms are available from the Administrative Office or your local Union office. A completed life insurance beneficiary card/form is the only document that the Trust will accept regarding your choice of beneficiary.

For example, if you execute a will or obtain dissolution of marriage, those documents or court orders will not be effective to change your designated beneficiary for your life insurance benefits nor can a beneficiary be changed by a power of attorney. You must instead complete and return a new beneficiary card/form to the Administrative Office.

Contact the Administrative Office if you are naming someone other than your legal Spouse to be your beneficiary, as the legal Spouse must sign their written agreement to this beneficiary designation on the beneficiary card/form.

Any designation or change of beneficiary will be effective on the date of its execution, regardless of whether or not you are living at the time it is received by the Administrative Office. In the event you die before any beneficiary designation or change is recorded, any death benefit that has already been paid will be deducted from the amount payable to a newly named beneficiary.

The beneficiary you designate for life insurance is also your beneficiary for the accidental death benefit (see Chapter 13, on Accidental Death and Dismemberment benefits).

If no beneficiary has been properly designated, your life insurance will be payable in equal shares to the first of the following categories of surviving beneficiaries:

Your:

- Legal Spouse
- Natural and legally adopted children
- Mother and father
- Brothers and sisters
- Estate

How To Continue Your Life Insurance If You Lose Eligibility (Conversion Option)

If your eligibility terminates while the Life Insurance Master Group Insurance Policy remains in force, your group term life insurance will be paid in the event your death occurs during the next 31 days.

Conversion: During the 31-day period, **you may convert your group term life insurance to an individual policy** without having to furnish evidence of good health. You may select any type of individual policy then customarily being issued by the Life Insurance Company, except term insurance or a policy containing disability benefits. The individual policy will be made effective at the end of the 31-day period. The premiums will be the same as you would ordinarily pay if you applied for an individual policy at that time.

Portability: Aside from the conversion provision described above, the Life Insurance Master Group Insurance Policy also contains a **portability feature** that may allow you to continue your life insurance and accidental death and dismemberment coverage after your eligibility is lost due to insufficient work hours. Specific criteria must be met to qualify for the portability benefit, and application for the benefit and premium payment must be made within 31 days following the date of your loss of eligibility. Refer to the Certificate of Coverage issued by the Life Insurance Company for details on the portability feature.

If you want to take advantage of the conversion or portability arrangement, contact the Life Insurance Company at their address listed in the Quick Reference Chart in the front of this document.

NOTE: If you re-establish your active eligibility under the Plan and then lose that eligibility once again, you cannot convert your group term life insurance to an individual policy if you already have an individual policy in effect as a result of a previous conversion.

How To File A Claim For Employee Life Insurance

Your beneficiary should send a certified copy of the death certificate, that includes the Social Security Number (SSN) of the deceased person, to the Administrative Office immediately.

The Insurance Company will make payment of the claim promptly upon receipt of all necessary documents.

If your beneficiary disagrees with the payment decision made in regard to the claim, the beneficiary can request a review of the decision, follow the claim appeal instructions provided to you by the Insurance Company.

All death certificates and correspondence should be submitted to the Administrative Office at:

Carpenters Southwest Administrative Office
ATTN: Life Insurance Department
533 South Fremont Avenue
Los Angeles, CA 90071-1706
(213) 386-8590 or (800) 293-1370

Chapter 12: DEPENDENT LIFE INSURANCE SUMMARY

This Chapter includes information on:

- What are the Dependent life insurance benefits
- Beneficiary for Dependent Life Insurance Benefits
- How your Dependent may continue life insurance if they lose eligibility
- Information on filing life insurance claims

The information in this Chapter applies only to Active Carpenters and Special Class Employees who are Eligible Individuals at the time of **death of their eligible Dependent** (and it applies regardless of which Medical Benefit Option under the Plan covers them). COBRA participants are NOT covered by this benefit.

For Life Insurance benefits, Dependent children are covered through the end of the month they turn age 19 or the end of the month in which they turn age 23 if they are full-time students. Refer to Chapter 3 for further details on the eligibility rules for Dependent life insurance.

The information in this Chapter is a brief **summary of Dependent life insurance coverage**. Further details on the coverage are found in the Certificate of Coverage issued by the Life Insurance Company listed on the Quick Reference Chart in the front of this document. If you need a copy of the Certificate, contact the Administrative Office or visit the Trust's website at www.carpenterssw.org.

What Are The Dependent Life Insurance Benefits?

Benefits are payable in the following amounts in the event of the death of an eligible Dependent from any cause while the Employee (from whom they derive Dependent status) is an Eligible Individual.

ELIGIBLE FAMILY MEMBERS	SCHEDULE OF AMOUNT OF LIFE INSURANCE BENEFIT
Spouse	\$3,000
Each child*	\$3,000

*Note: In the case of an infant death, the child must have been born alive in order for a benefit to be payable.

Your Beneficiary For Dependent Life Insurance Benefits

The amount of life insurance shown in the above schedule is payable to you (the Active Carpenter or Special Class Employee who is an Eligible Individual from whom the Dependent's status was derived) if living, otherwise to your estate.

How Your Dependents May Continue Life Insurance If They Lose Eligibility (Conversion Option)

If your Dependent Spouse or Dependent Child's eligibility terminates while the Life Insurance Master Group Insurance policy remains in force, any insurance then in effect on your Dependent's life may be **converted to any type of individual life insurance policy** then customarily being issued by the Life Insurance Company, except term insurance or any policy containing disability benefits, without your Dependent's having to furnish evidence of good health.

To convert the insurance, you or your Dependent must make application to the Life Insurance Company within 31 days from the termination of your Dependent's insurance. The premiums will be the same as you or your Dependent would ordinarily pay if your Dependent applied for an individual policy at that time.

If you want to take advantage of this conversion arrangement contact the Life Insurance Company at their address listed in the Quick Reference Chart in the front of this document.

NOTE: If you re-establish your active eligibility under the Trust and then lose that eligibility once again, you or your Dependent cannot convert the Dependent's group term life insurance to an individual policy if the Dependent already has an individual policy in effect as a result of a previous conversion.

The life insurance benefit for your Dependent will be paid if the death of your Dependent occurs during the period in which application for conversion may be made.

How To File A Claim For Dependent Life Insurance Benefits

Whenever there is a claim, your beneficiary should send a certified copy of the death certificate, that includes the Social Security Number (SSN) of the deceased person, to the Administrative Office immediately.

All death certificates and correspondence should be submitted to the Administrative Office at:

Carpenters Southwest Administrative Office
ATTN: Life Insurance Department
533 South Fremont Avenue
Los Angeles, CA 90071-1706
(213) 386-8590 or (800) 293-1370

The insurance company will make payment of the claim promptly upon receipt of all necessary documents.

If you disagree with the decision made in regard to your claim, follow the claim appeal instructions provided to you by the Insurance Company.

Chapter 13: EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS SUMMARY

This Chapter includes information on:

- What are the AD&D benefits
- Your beneficiary
- What is not covered
- Information on filing claims

The information in this Chapter applies **only to Active Carpenters and Special Class Employees** who are Eligible Individuals at the time of their death or covered injury (and it applies regardless of which medical benefit Option under the Plan covers them). COBRA participants and Dependents are NOT covered for this benefit.

The information in this Chapter is a brief summary of your accidental death and dismemberment (AD&D) coverage. Further details on the coverage are found in the Certificate of Coverage issued by the Life Insurance Company listed in the Quick Reference Chart in the front of this document. If you need a copy of the Certificate, contact the Administrative Office.

What Are The AD&D Benefits?

Your accidental death and dismemberment benefit will be paid for any of the following losses through accidental means, on or off the job, occurring when you are an Eligible Individual. The injury must be sustained while you are insured, and the loss must occur within 365 days after such injury. Payment will be made regardless of any other benefits you may receive.

Schedule Of AD&D Benefits	
Description of Loss	Benefit Payable
Your death	\$20,000 (Paid to your beneficiary)
Loss of both hands, both feet or sight of both eyes	\$20,000 (Paid to you)
Loss of one hand and one foot	\$20,000 (Paid to you)
Loss of speech and hearing in both ears	\$20,000 (Paid to you)
Loss of one hand or one foot and sight in one eye	\$20,000 (Paid to you)
Loss of one hand or one foot or sight in one eye	\$10,000 (Paid to you)
Loss of speech	\$5,000 (Paid to you)

Schedule Of AD&D Benefits	
Description of Loss	Benefit Payable
Loss of hearing in both ears	\$5,000 (Paid to you)
Quadriplegia (total paralysis of both upper and lower limbs)	\$20,000 (Paid to you)
Paraplegia (total paralysis of both lower limbs)	\$10,000 (Paid to you)
Hemiplegia (total paralysis of upper and lower limbs on one side of the body)	\$10,000 (Paid to you)
Loss of thumb and index finger of one hand	\$5,000 (Paid to you)

Loss of sight, hearing or speech must be complete and irrecoverable. Loss of an arm, leg, hand or foot must be complete severance at or above the wrist or at or above the ankle. Loss of a thumb and index finger must be complete severance at or above the metacarpophalangeal joints.

The **total maximum amount payable for all losses will not exceed \$20,000** unless otherwise specified by any applicable additional benefit or additional provision contained in the Certificate of Coverage issued by the Life Insurance Company.

There are several additional benefits described in the Certificate of Coverage including:

- Additional benefit for child education
- Additional benefit for repatriation
- Additional benefit for seat belt and air bag
- Additional benefit for common carrier accident
- Additional benefit for Spouse education
- Additional benefit for child care
- Additional benefit for coma
- Additional benefit for occupational assault

Refer to the Certificate of Coverage issued by the Life Insurance Company for details on these additional benefits.

Your Beneficiary For AD&D Benefits

Your beneficiary for the accidental death benefit is the same as your beneficiary for your life insurance. You may request a change of beneficiary at any time by submitting a new beneficiary card/form. Beneficiary cards/forms are available from the Administrative Office or your local Union office.

AD&D Exclusions: What Is Not Covered

No payment will be made for an Accidental Death and Dismemberment (AD&D) Benefit for any death or loss that results directly or indirectly from, or was in any manner or degree associated with or caused by any one or more of the following:

- a. suicide or attempted suicide or self-inflicted injury whether committed while sane or insane
- b. physical or mental illness
- c. bacterial infection or bacterial poisoning except infection from a cut or wound caused by an accident
- d. riding in or descending from an aircraft as a pilot or crew member
- e. any armed conflict, whether declared as war or not, involving any country or government
- f. Injury suffered while in the military service for any country or government
- g. Injury which occurs when you commit or attempt to commit a felony
- h. Your intoxication. Intoxication means your blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the accident occurred
- i. loss sustained or contracted in consequence of your being under the influence of any controlled substance unless administered on the advice of a doctor.

How To File A Claim For Employee Accidental Death And Dismemberment Benefits

The Administrative Office should be notified immediately of a claim. The necessary forms will be sent to the claimant so that payment of the claim may be made promptly.

All death certificates and correspondence should be submitted to the Administrative Office at:

Southwest Carpenters Administrative Office
ATTN: AD&D Benefits Department
533 South Fremont Avenue
Los Angeles, CA 90071-1706
(213) 386-8590 or (800) 293-1370

If you or your beneficiary disagrees with the payment decision made in regard to the claim, it can be appealed by following the claim appeal instructions provided to you by the Insurance Company. Please alert your beneficiary to the existence of that information.

Chapter 14: GENERAL PROVISIONS AND PLAN NOTICES

This Chapter includes information on:

- Privacy of Health Information
- Your rights under ERISA
- General Plan Provision information
- Plan Facts

Privacy Of Health Information

The Plan is obligated to comply with rules included in the Health Insurance Portability and Accountability Act (HIPAA) regarding how your Health Information may be used and disclosed and how you can get access to it.

The Plan's Privacy Notice can be viewed online at the Administrative Office's website www.carpenterssw.org and a copy is available at no charge from the Administrative Office.

It may be necessary for you to complete and submit to the Administrative Office a **HIPAA authorization form** if you want the Administrative Office to release information about you to someone else such as your Union representative, Spouse or adult children. Likewise, if your Spouse or child 18 years of age or older wants the Administrative Office to release information about them to someone else such as you, it may be necessary for them to complete and submit a HIPAA authorization form.

The authorization forms can be obtained from the Administrative Office or on the Trust's website at www.carpenterssw.org.

Effective April 14, 2003, a federal law, the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**, as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that self-funded group health plans (like the one described in this document hereafter referred to as the "Plan"), maintain the privacy of your personally identifiable Health Information (called **Protected Health Information or PHI**).

- The term "**Protected Health Information**" (**PHI**) includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.
- **PHI does not include** Health Information contained in employment records held by your employer in its role as an employer, including but not limited to Health Information on disability, work-related illness/injury, sick leave, Family and Medical Leave (FMLA), life insurance, AD&D insurance, Dependent care FSA, Drug testing, etc.

A complete description of your rights under HIPAA can be found in the **Plan's Notice of Privacy Practices**, which was previously distributed to you upon enrollment in the Plan and is also available from the Administrative Office. Information about HIPAA in this document is not intended to and cannot be construed as the Plan's Notice of Privacy Practices.

The Plan, and the Plan Sponsor (the Board of Trustees of the Southwest Carpenters Health and Welfare Trust), will not use or further disclose information that is protected by HIPAA (“protected Health Information or PHI”) except as necessary for Treatment, Payment, Health Care Operations and Plan administration, or as permitted or required by law. **In particular, the Plan will not, without your written authorization, use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.**

Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim, appeal or for other reasons related to the administration of the Plan.

- a. **The Plan’s Use and Disclosure of PHI:** The Plan will use Protected Health Information (PHI), without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by the privacy regulations under HIPAA. Specifically, the Plan will use and disclose Protected Health Information for purposes related to health care Treatment, Payment for health care, and Health Care Operations (sometimes referred to as TPO), as defined below.

Treatment is the provision, coordination, or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your health care providers.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:

- Determination of eligibility, coverage, cost sharing amounts (e.g. cost of a benefit, Plan maximums, and Copayments as determined for an individual’s claim), and establishing employee contributions for coverage;
- Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other Payment disputes), coordination of benefits, subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing; and
- Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization management, including precertification/preauthorization, concurrent review and/or retrospective review.

Health Care Operations includes, but is not limited to:

- Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of Payment or coverage policies, quality assessment, patient safety activities;
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about Treatment alternatives and related functions;
- Underwriting (the Plan does not use or disclose PHI that is Genetic Information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), enrollment, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;

- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
 - Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, Plan Sponsors, or other customers;
 - Compliance with and preparation of documents required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500's, Summary Annual Reports and other documents.
- b. **When an Authorization Form is Needed:** Generally, the Plan will require that you sign a valid authorization form (available from the Administrative Office) in order for the Plan to use or disclose your PHI **other than** when you request your own PHI, a government agency requires it, or the Plan uses it for Treatment, Payment, or Health Care Operations or other instance in which HIPAA explicitly permits the use or disclosure without authorization. The Plan's Notice of Privacy Practices also discusses times when you will be given the opportunity to agree or disagree before the Plan uses and discloses your PHI.
- c. **The Plan will disclose PHI to the Plan Sponsor only** upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to:
1. Not use or disclose the information other than as permitted or required by the Plan Document or as required by law;
 2. Ensure that any agents, including their subcontractors, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules;
 3. Not use or disclose the information for employment-related actions and decisions;
 4. Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor, (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices);
 5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
 6. Make PHI available to the individual in accordance with the access requirements of HIPAA;
 7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
 8. Make available the information required to provide an accounting of PHI disclosures;
 9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the Dept. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA;
 10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

11. Notify you if a breach of your unsecured Protected Health Information (PHI) occurs.
- d. **In order to ensure that adequate separation between the Plan and the Plan Sponsor is maintained** in accordance with HIPAA, only the following employees or classes of employees may be given access to use and disclose PHI:
1. Administrative Office Staff who administer the Plan.
 2. Business Associates under contract to the Plan including but not limited to the medical plan claims administrator, preferred provider organization network, utilization management company, outpatient Prescription Drug program, and COBRA administrator.
- e. The persons described in subsection d. above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance. **Issues of noncompliance** (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy Officer whose address and phone number are listed on the Quick Reference Chart in the front of this document.

If you are a minor and have concerns about the Plan releasing PHI to your parents or guardian, please contact the Administrative Office.

- f. Effective April 21, 2005 in compliance with **HIPAA Security** regulations, the Plan Sponsor will:
1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,
 2. Ensure that the adequate separation discussed in subsection d. above, specific to electronic PHI, is supported by reasonable and appropriate security measures,
 3. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and
 4. Report to the Plan any Security Incident of which it becomes aware concerning electronic PHI.

Your Rights Under ERISA

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

Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Administrative Office and at other specified locations, such as worksites and union halls, all documents governing the operation of the Plan. These documents include insurance contracts and Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefits Administration).
- Obtain, upon written request to the Administrative Office, copies of documents governing the operation of the Plan. These include insurance contracts, Collective Bargaining Agreements, copies of the latest annual report (Form 5500 Series), current Summary Plan Description/Plan

Document with amendments and Summary of Material Modifications. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, Spouse, or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review Chapter 3 of this document, or HMO Medical Plan booklet(s), for the rules governing your COBRA continuation coverage rights (and in the case of HMO coverage in California, Cal-COBRA rights).

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a 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 do not receive it within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Any legal action filed under ERISA § 502(a) against the Trust or Plan by an Employee, Participant or beneficiary may only be brought in Federal District Court in Los Angeles County, California.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Administrative Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA) (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory. Alternatively, you may obtain assistance by calling EBSA toll-free at (866) 444-EBSA (3272) or writing to the following address:

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

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of EBSA. For single copies of publications, contact the EBSA brochure request line at (800) 998-7542 or contact the EBSA field office nearest you.

You may also find answers to your Plan questions and a list of EBSA field offices at the website of EBSA at <http://www.dol.gov/ebsa>.

General Plan Provision Information

Determining Documents

If you are eligible under the Plan, your rights will be determined by:

- the Summary Plan Description/Plan Document entitled “Southwest Carpenters Health and Welfare Plan for Active Carpenters Restated January 1, 2019” and amendments and restatements thereof relating to all eligibility requirements and benefits provided by the Anthem Medical PPO Plan with outpatient Prescription Drug benefits, and long term disability, life and AD&D benefits provided by the Trust;
- the Kaiser Service Agreements relating to the HMO medical plan for Hospital, medical, and Prescription Drug benefits provided by Kaiser;
- the UnitedHealthcare Agreements relating to the dental plan options provided by UnitedHealthcare;
- the UnitedHealthcare Agreements relating to vision plan benefits provided by UnitedHealthcare;
- the MetLife Policies/Certificates relating to the life insurance and accidental death and dismemberment benefits.

The information contained in this booklet is intended to outline the eligibility rules and health care benefits.

Authority

The Board has complete and total authority and discretion in the design, adoption, amendment, modification, termination, operation, and administration of the Plan, Trust, and Trust Fund. Any interpretation of the Trust Agreement, Summary Plan Description/Plan Document or any other document bearing upon the Plan and Trust, and dispute as to status as an Eligible Individual, or eligibility for, type, amount, or duration of benefits or any right or claim to payments under the Plan

or from the Trust will be determined and resolved by the Board or its duly authorized Delegate in their complete discretion. Any decisions will be binding on all parties; subject only to such judicial review as may be required by applicable law.

See Chapter 15 for information on what to do if you disagree with the decision made in regard to a claim you have filed.

To the extent benefits under the Plan are provided by an insurance company, HMO Medical Plan, or similar organization, any dispute as to eligibility, type, amount, or duration of benefits will be resolved by the appropriate insurance carrier or service organization and participants will have no right or claim regarding such benefits against the Plan or Trust or any of the Trustees.

Limited Liability for Payment

The Anthem Medical PPO Plan, including Prescription Drug coverage, and long-term disability benefits described in this booklet are not insured by any contract of insurance, and there is no liability on the Board of Trustees or any individual or entity to provide payments over and beyond the assets of the Trust.

No Trust Liability for Provider-Related Loss or Injury

Under no circumstances will the Trust be liable for the negligence, wrongful acts, or omissions of any Physician, Dentist, Hospital, laboratory, or other person or organization performing services or supplying materials in connection with benefits under the Plan.

No Liability under Reciprocity Agreements for Obligations of other Participating Trusts

If you establish eligibility under the terms of the Health and Welfare Reciprocal Agreement sponsored by the United Brotherhood of Carpenters and Joiners of America or any Reciprocal Agreement entered into by the Trust, it is expressly understood and agreed that none of the participating Trust funds assumes any of the liabilities or obligations of the other participating trust funds. Each participating Trust fund will be liable solely and exclusively for health and welfare benefits due under its own plan and no fund will be liable for the acts or omissions of another fund.

No Replacement for Workers' Compensation

The benefits provided by the Trust are not in lieu of and do not affect any requirement for coverage under Workers' Compensation insurance laws or similar legislation. For self-employed participants, benefits are not in lieu of work for remuneration or profit.

Not a Contract of Employment

Your participation in the Plan does not guarantee your continued employment with any Contributing Employer. The Plan is not an employment contract.

Nothing in the Plan gives you a right to employment or affects the rights of a Contributing Employer to terminate your employment at any time.

Non-assignment

Coverage and your rights to receive any benefits under this Plan may not be assigned either before or after receiving health care services without the express written permission of the Plan Sponsor. Benefits payable shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person or entity without the express written permission of the Plan Sponsor; however, a Plan Participant may direct that benefits due to the Participant, be paid to a Health Care Provider in consideration for Hospital, medical, Prescription Drug, dental and/or vision services rendered, or to be rendered.

A direction to pay a Health Care Provider is not an assignment of any right under this Plan or under ERISA, is not authority to act on a Participant’s behalf in pursuing and appealing a benefit determination under the Plan, is not an assignment of rights respecting anyone’s fiduciary duty, and is not an assignment of any legal or equitable right to institute any court proceeding. Any attempted assignment is void (invalid) and not recognized by the Plan, if performed without the Plan’s express written permission (consent).

Headings, Font And Style Do Not Modify Plan Provisions

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

Plan Facts

Plan Facts		
Name of Plan	Southwest Carpenters Health and Welfare Plan for Active Carpenters	
Type of Plan	Employee welfare benefit plan (group health plan) maintained for the purpose of providing life insurance, accidental death and dismemberment insurance, disability benefits, and health care benefits in the event of sickness or injury for Eligible Individuals	
Plan Number	501	
Funding Medium	Benefits of the Plan are provided under service agreements or insurance contracts or directly from the Trust’s assets, which are accumulated under the provisions of the Collective Bargaining Agreements and the Trust Agreement and are held for the purpose of providing benefits to covered participants and defraying reasonable operating costs.	
	Insured Benefits	Self-funded Benefits
	Kaiser Deductible HMO Medical Plan	Anthem Medical PPO Plan and Outpatient Prescription Drug Benefits
	Dental Plan Options	Long Term Disability Benefits
	Vision Plan	
	Life Insurance	
	Accidental Death and Dismemberment Insurance	

Plan Facts	
Source of Contributions	<p>The benefits for Eligible Individuals described in this booklet are provided through employer contributions to this Plan and net income thereon, if any. The amount of employer contributions to this Plan is determined by the provisions of the Collective Bargaining Agreements, participation agreements or other agreements with employer representatives.</p> <p>Additionally, self-payments for coverage are accepted as explained in the Eligibility Chapter.</p> <p>The Collective Bargaining Agreements require contributions to this Plan at a fixed rate per hour worked. Upon written request, the Administrative Office will provide you information as to whether a particular employer is contributing to this Plan on behalf of participants working under the Collective Bargaining Agreements.</p> <p>Benefits for COBRA participants are paid for by COBRA participants.</p>
Plan Year	<p>The date of the end of the Plan year is December 31. The fiscal records of the Plan are kept separately for each Fiscal Plan Year. The Fiscal Plan Year begins January 1 and ends December 31.</p>
Plan Sponsor	<p>The Board of Trustees of Southwest Carpenters Health and Welfare Trust. Upon written request, the Administrative Office will provide you information as to whether a particular employer or union is a sponsor of the Plan and the address of the employer or union.</p>
Employer Identification Number (EIN)	<p>The number assigned to the Plan by the Internal Revenue Service is 95-6042873.</p>
Plan Administrator	<p>The Board of Trustees of Southwest Carpenters Health and Welfare Trust 533 South Fremont Avenue Los Angeles, CA 90071-1706 Telephone: (213) 386-8590 or (800) 293-1370</p> <p>The Board of Trustees is the Plan Administrator. This means that the Board of Trustees is responsible for seeing that information regarding the Plan is reported to government agencies and disclosed to Plan participants and beneficiaries in accordance with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>Further information on Plan administration and the names and addresses of the Trustees as of the date this booklet was issued are provided below.</p>
Agent for Service of Legal Process	<p>DeCarlo & Shanley, P.C. 533 South Fremont Avenue, 9th Floor Los Angeles, CA 90071-1706 or Executive Administrator of the Southwest Carpenters Health & Welfare Trust for Active Carpenters c/o Carpenters Southwest Administrative Corporation 533 South Fremont Avenue Los Angeles, CA 90071-1706 Legal process may also be served on a Plan Trustee.</p>

Administration of the Plan

The Plan is governed and administered by the Board of Trustees, which consists of employer and Union representatives selected by the employers and unions in accordance with the Collective Bargaining Agreements and Trust Agreement that relates to this Plan. If you wish to contact the Board of Trustees, you may do so at the address and phone number shown for “Plan Administrator” in the chart above.

The recordkeeping functions of the Plan are performed by:

Carpenters Southwest Administrative Corporation (CSAC)
533 South Fremont Avenue
Los Angeles, CA 90071-1706
Telephone (213) 386-8590 or (800) 293-1370

Identity and Address of the Board of Trustees

The Trustees of the Plan, as of the Effective Date of this document, are as follows:

Management Trustee	Labor Trustee
Curtis Conyers, Jr. (AGC) Carpenters Southwest Administrative Corporation 533 South Fremont Avenue, 10 th Floor Los Angeles, CA 90071	Pete Rodriguez Southwest Regional Council of Carpenters 533 South Fremont Avenue, 10 th Floor Los Angeles, CA 90071
Kim Fromer (RCA) Carpenters Southwest Administrative Corporation 533 South Fremont Avenue, 10 th Floor Los Angeles, CA 90071	Daniel Langford Southwest Regional Council of Carpenters 533 South Fremont Avenue, 10 th Floor Los Angeles, CA 90071
Richard Harris (RCA) Carpenters Southwest Administrative Corporation 533 South Fremont Avenue, 10 th Floor Los Angeles, CA 90071	Harry Beggs Southwest Regional Council of Carpenters 533 South Fremont Avenue, 10 th Floor Los Angeles, CA 90071
Mark Thurman (AGC) Carpenters Southwest Administrative Corporation 533 South Fremont Avenue, 10 th Floor Los Angeles, CA 90071	Frank Hawk Southwest Regional Council of Carpenters 533 South Fremont Avenue, 10 th Floor Los Angeles, CA 90071
Bert Lewitt (UGC) Carpenters Southwest Administrative Corporation 533 South Fremont Avenue, 10 th Floor Los Angeles, CA 90071	Josh Raper Southwest Regional Council of Carpenters 533 South Fremont Avenue, 10 th Floor Los Angeles, CA 90071
Calvin Yoshida (UGC) Carpenters Southwest Administrative Corporation 533 South Fremont Avenue, 10 th Floor Los Angeles, CA 90071	Mercy Urrea Southwest Regional Council of Carpenters 533 South Fremont Avenue, 10 th Floor Los Angeles, CA 90071
Travis Winsor, (WWCA) Carpenters Southwest Administrative Corporation 533 South Fremont Avenue, 10 th Floor Los Angeles, CA 90071	Sean Hartranft Southwest Regional Council of Carpenters 533 South Fremont Avenue, 10 th Floor Los Angeles, CA 90071
Steve Jones (NCA) Carpenters Southwest Administrative Corporation 533 South Fremont Avenue, 10 th Floor Los Angeles, CA 90071	

Identity of Providers of Benefits

Benefits are provided directly by the Trust (self-funded) for the Anthem Medical PPO Plan including outpatient Prescription Drug benefits, and disability benefits described in this booklet. The Table of Contents at the front of this Summary Plan Description/Plan Document provides reference to eligibility rules, claims and appeals processes, glossary of terms, etc.

HMO medical and Prescription Drug benefits are fully insured and provided through Kaiser, and Anthem Blue Cross Blue Shield.

Dental benefits are fully insured and provided by UnitedHealthcare. Vision benefits are fully insured and provided by UnitedHealthcare.

The Life Insurance and Accidental Death and Dismemberment benefits are fully insured and provided by MetLife.

Refer to the **Quick Reference Chart** in the front of this document for the contact information for the insurance companies listed here. The complete terms of the insured benefits are set forth in the applicable agreement with the insuring organization. (See also “Determining Documents” under “General Plan Provision Information” earlier in this Chapter.) The complete terms of the self-funded benefits are set forth in this document.

Collective Bargaining Agreements

Contributions to this Plan are made on behalf of each Active Carpenter in accordance with Collective Bargaining Agreements between the Southwest Regional Council and Local Unions affiliated with the United Brotherhood of Carpenters and Joiners of America and employers in the industry.

The Administrative Office will provide you, upon written request, a copy of the Collective Bargaining Agreement applicable to you. The Collective Bargaining Agreements are also available for examination at the office of the Plan Administrator.

Trust Fund

The Trust’s assets and reserves are held in trust by the Board of Trustees of the Southwest Carpenters Health and Welfare Trust.

Plan Amendment or Termination

While the Plan has been providing health and welfare benefits to Active Carpenters and their families without interruption since 1955 and the Trust remains in sound financial condition, and the Board intends to continue provision of benefits indefinitely, the Plan and Trust depend upon contributions pursuant to Collective Bargaining Agreements in order to continue the provision of benefits.

The Board of Trustees expressly reserves the right, solely at its discretion at any time and from time to time, in accordance with the procedures specified in Article VI of the Trust Agreement,

- to terminate the Plan, or amend in any respect any provision of the Plan,
- to alter or postpone the method of payment of any benefit and
- to amend or rescind any other provisions of the Plan or a decision upon a claim or any appeal of a denial of a claim under the Plan.

In the unlikely event the Plan is terminated, any and all monies and assets remaining in the Trust Fund, after payment of expenses, will be used for the exclusive benefit of participants, as determined solely and absolutely at the discretion of the Board of Trustees in accordance with the Trust Agreement.

Chapter 15: CLAIM FILING AND CLAIM APPEALS

This Chapter includes information on:

- **How to File a Claim for Anthem Medical PPO Plan Benefits**
- **Claim Review Procedures**
- **Initial Claim Determination**
- **How to File a Claim Appeal**
- **External Review Process**
- **Important Legal Rules**

How To File A Claim For Benefits Under The Anthem Medical PPO Plan

NOTE: The discussion below applies to “post-service claims”- claims you submit after you have received a service.

A claim for post-service benefits is a request for Plan benefits (that is not a pre-service claim) made by you or your Authorized Representative, in accordance with the Plan’s claims procedures, described in this Chapter. See also the “Key Definitions” section of this Chapter for a definition of a “claim” and the information on what is and is not considered a claim.

Plan benefits for post-service claims are considered for payment upon receipt of a **written** (or electronic where appropriate) proof of claim, commonly called a bill. A completed claim or bill usually contains the necessary proof of claim but sometimes additional information or records may be required. Generally, a Claims Administrator will not accept a balance due statement, cash register receipts, photocopy, canceled checks or credit card receipts as proof of claim.

Fortunately, network Health Care Providers send their bill directly to the Plan. This means that when using network providers there are generally no forms or claims or paperwork to complete. Then, for eligible claims, Plan benefits for a network provider, Hospital or Health Care Facility will be paid directly to the network provider or facility. Plan benefits for Surgery will usually be paid directly to the network surgeon and anesthesiologist providing the services.

For eligible claims, the Plan pays its portion of the billed services and you, the covered person, are responsible to pay your portion of the claim to the provider. When Deductibles, Coinsurance or Copayments apply, you are responsible for paying your share of these charges.

Claim Forms

Occasionally a health care provider (typically a non-network provider) will send a claim directly to you. In this case you should contact the Appropriate Claims Administrator (defined in this Chapter) to find out if they require you to complete a claim form. If a claim form is necessary, you can obtain them from the Trust’s website at www.carpenterssw.org or by calling the Appropriate Claims Administrator toll-free at (833) 224-6930.

When a Separate Claim Form Is Required for Non-PPO Providers

You must submit a new claim form for each new sickness or injury, and you must submit a separate claim form for each person. Be sure to include the member's Social Security number on all correspondence.

You do NOT have to submit an additional claim form if your bills are for a continuing disability and you have filed a **signed** claim form within the past calendar-year period. Mail any further bills or statements for any covered medical or Hospital services to the Claims Administrator as soon as you receive them.

Claims for Hospital Services

If you are admitted to a Hospital, you need to show your Southwest Carpenters Health and Welfare Trust medical identification (ID) card with the Anthem PPO logo on it and provide the member's Social Security Number to the admitting office and ask that the claim be sent to the following Medical Plan Claims Administrator's address:

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

Claims for Services from PPO Providers Other Than Hospitals

If you use a PPO provider, show your Southwest Carpenters Health and Welfare Trust medical identification (ID) card with the Anthem PPO logo on it and give the provider your Social Security Number. The PPO provider will submit a claim directly to the Claims Administrator. See also "Electronic Submissions" below.

Claims for Services from Non-PPO Providers Other Than Hospitals

If you use a non-PPO provider, you may need to file a claim yourself using a claim form. Check the claim form to be certain that all applicable portions of the form are completed and that you are submitting all itemized bills. By doing so, you will speed the processing of your claim. If the claim forms have to be returned to you for information, delays in payment will result.

NOTE: Bills submitted for appliances necessary to treat your illness or injury should include the date purchased, the name of the person for whom the appliance is prescribed and the prescribing Physician's name. A separate claim form must be filed for each patient.

Mail your completed claim form to the Medical Plan Claims Administrator at the following address:
Anthem Blue Cross, P.O. Box 60007, Los Angeles, CA 90060-0007

Electronic Submission of Claims

If your health care provider submits a claim electronically, it must include the following information:

- The member's (Carpenter's) name and Social Security number
- The patient's name, date of birth, and relationship to you
- The date(s) of service
- The CPT procedure codes-the codes for Physician services and other health care services found in the most current edition of the Current Procedural Terminology, as maintained and distributed by the American Medical Association
- The ICD codes-the diagnosis codes found in the most recent International Classification of Diseases, Clinical Modification, as maintained and distributed by the U.S. Department of Health and Human Services
- The billed charge(s)

- The number of units (for anesthesia and certain other claims)
- The Federal taxpayer identification number (TIN) of the provider
- The provider's billing name and address
- If treatment is due to an accident, accident details
- Information on other insurance coverage, if any.

Deadline for Medical Plan Claim Submission to the Plan

You should submit your health care claim **within 90 days** from the date on which covered expenses were first incurred. Failure to file your health care claim within 90 days will not invalidate or reduce your claim, if it was not reasonably possible to file the claim within that time. However, in that case the health care claim must be submitted as soon as reasonably possible and **in no event later than 15 months after the date on which the charges were incurred**. If the health care claim is submitted more than **15 months** after the date on which the charges were incurred, it will be denied.

For Dental claim submission see Chapter 7. For Vision claim submission, see Chapter 8. For LTD claim submission see Chapter 10.

There may be times during the filing or appeal of a claim that you are asked to submit additional information. You will be told how much time is allowed for you to submit this additional information.

The Plan is not legally required to consider information submitted after the stated timeframe.

Questions?

If you have any questions about submitting your claim, contact the Appropriate Claims Administrator. For information on what to do if you disagree with the decision made in regard to your claim, see "Claims Review Procedures" below in this Chapter.

Claims Review Procedures

NOTE: The information provided here is applicable only to benefits and eligibility determinations under the Anthem Medical PPO Plan (including outpatient Prescription Drugs), and the long-term disability benefits.

If you are covered under any insured HMO Medical Plan, or an insured vision or insured dental plan, it is not necessary to file a claim when their participating providers render services. Those organizations have their own review and appeals procedures, which are described in the Disclosure Form/Evidence of Coverage booklets, copies of which may be obtained from the website of the Carpenters Southwest Administrative Corporation at www.carpenterssw.org.

The Plan takes steps to ensure that Plan provisions are applied consistently with respect to you and other similarly situated Plan participants. The claims procedures outlined in this Chapter are designed to afford you a full, fair and fast review of the claim to which it applies.

The Plan will take steps so claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) will not be made based upon the likelihood

that the individual will support the denial of benefits. Health care claim review experts will be selected based on their professional qualifications.

Additional Information Needed

There may be times during the filing or appeal of a claim that you are asked to submit additional information. You will be told (in writing) how much time is allowed for you to submit this additional information. The Plan is not legally required to consider information submitted after these stated time frames.

Key Definitions Related To Claims Procedures

You should refer to these definitions below when reviewing particular claim filing and appeal information in this Chapter.

Adverse Benefit Determination: For the purpose of the initial and appeal claims processes, an Adverse Benefit Determination for a health care claim is defined as:

- a **denial, reduction, or termination of**, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual’s eligibility to participate in this Plan or a determination that a benefit is not a covered benefit; and
- a reduction in a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate; or
- a Rescission of coverage including disability coverage, whether or not there is an adverse effect on any particular benefit at that time.

Appropriate Claims Administrator: The various organizations under contract to the Fund to perform claims adjudication services to administer claims and/or claim appeals. “Claims Adjudication” refers to the determination of the Plan’s payment or financial responsibility, after the Plan participant’s benefits are applied to a claim.

Claims are adjudicated by several different claims administrators depending on which type of benefit is being sought. The organizations that administer each type of claim (the Appropriate Claims Administrator) are outlined in the chart below. (For contact information for each claims administrator, see the Quick Reference Chart in the front of this document.)

Type of Claim Processed	Appropriate Claims Administrator	Urgent Appeal	Concurrent Appeal	Pre-service Appeal	Post-Service Appeal	Level of Appeal
Post-service claims	Claims Administrator for the Anthem Medical PPO Plan	NA	NA	NA	X	Level One to Anthem Medical PPO Plan Claims Administrator. Level Two to the Benefits Committee of the Board of Trustees.

Type of Claim Processed	Appropriate Claims Administrator	Urgent Appeal	Concurrent Appeal	Pre-service Appeal	Post-Service Appeal	Level of Appeal
Urgent, concurrent and pre-service claims	Preauthorization Department for the Anthem Medical PPO Plan	X	X	X	NA	The Level One claim appeal process is managed by the Anthem Medical PPO Plan Preauthorization Department.
Outpatient Drug urgent, concurrent, preservice and post-service claims	Outpatient Prescription Drugs for the Anthem Medical PPO Plan	X	X	X	X	Level One to the outpatient Prescription Drug Claims Administrator (PBM).
Pre-service, urgent, concurrent and post-service dental claims	Dental Plan Claims Administrator	X	X	X	X	The Level One claim appeal process is managed by the Dental Plan Claims Administrator.
LTD Disability claims	Administrative Office	NA	NA	NA	NA	Level One to the Benefits Committee of the Board of Trustees.
Eligibility	Administrative Office	NA	NA	NA	X	Level One appeal for Eligibility to the Administrative Office. Level Two to the Benefits Committee of the Board of Trustees.
Life Insurance and AD&D claims	Administrative Office and the Life Insurance Company	NA	NA	NA	X	The claim appeal process is managed by the Life Insurance and AD&D Insurance Company.
Post service Dental claims	Dental Plan Insurance Company	NA	NA	NA	X	The Level One claim appeal process is managed by the Dental Plan Insurance Company.

Type of Claim Processed	Appropriate Claims Administrator	Urgent Appeal	Concurrent Appeal	Pre-service Appeal	Post-Service Appeal	Level of Appeal
Post-service vision claims	Vision Plan Insurance Company	NA	NA	NA	X	The Level One claim appeal process is managed by the Vision Plan Insurance Company.

Authorized Representative:

An Authorized Representative, such as your Spouse, may complete a claim submission for you if you are unable to complete it yourself and have previously designated the individual to act on your behalf. A **form** can be obtained from the Administrative Office to designate an Authorized Representative. The Plan may request additional information to verify that this person is authorized to act on your behalf. **Even if you have designated an Authorized Representative to act on your behalf, you must personally sign a claim form and file it with the Anthem Medical PPO Plan Claims Administrator at least annually.**

This Plan recognizes an Authorized Representative as any person at least 18 years old whom you have designated in writing as the person who can act on your behalf to file a claim and appeal an Adverse Benefit Determination under this Plan (because of your death, disability or other reason acceptable to the Plan).

An Authorized Representative under this Plan can include a **network** Health Care Professional.

Under this Plan **non-network providers cannot automatically be designated to be an Authorized Representative.** Instead, the Plan participant must make a written designation if they desire a non-network provider to be their Authorized Representative for a claim appeal; however, this designation does not extend to permit the non-network provider to file legal action on behalf of the participant or their claim appeal. The written Authorized Representative request should include the Plan participant’s name and contact information, and signature, along with the Authorized Representative’s name, address and phone number. The Authorized Representative request should be submitted to the Appropriate Claims Administrator.

Where an individual is unable to provide a written statement, the Plan will require written proof that the proposed Authorized Representative has the power of attorney for health care purposes (e.g. notarized power of attorney for health care purposes, court order of guardianship/conservatorship or is the individual’s legal Spouse, parent, grandparent or child over the age of 18).

Once the Plan receives an Authorized Representative form all future claims and appeals-related correspondence will be routed to the Authorized Representative and not the individual. The Plan will honor the designated Authorized Representative until the designation is revoked, or as mandated by a court order. A participant may revoke a designated Authorized Representative status by submitting a completed change of Authorized Representative form available from the Appropriate Claims Administrator. Forms should be returned to the Appropriate Claims Administrator.

In the case of an **urgent care claim**, if a Health Care Professional with knowledge of your medical condition determines that a claim involves urgent care (within the meaning of the definition of urgent care), such Health Care Professional will be considered by this Plan to be your Authorized

Representative bypassing the need for completion of the Plan's written Authorized Representative form.

The Plan reserves the right to withhold information from a person who claims to be your Authorized Representative if there is suspicion about the qualifications of that individual or the circumstances of the Authorized Representative or its process appear to be defective, fraudulent or otherwise invalid.

Claim: For purposes of benefits covered by these procedures, a claim is a request for a Plan benefit made by an individual (commonly called the "claimant" but hereafter referred to as "you") or that individual's Authorized Representative (as defined later in this Chapter) in accordance with the Plan's claims procedures, described in this Chapter.

There are **five (5) types of claims applicable to the benefits described in this booklet**. Four types of claims have to do with health care benefits under the Anthem Medical PPO Plan including pre-service, urgent, concurrent, and post-service claims (these terms defined in this section) and one type of claim has to do with disability claims (as that term is defined in this section).

A claim must include the following elements to trigger the Plan's claims processing procedures:

- a. be **written or electronically** submitted (oral communication is acceptable only for urgent care claims),
- b. be **received by the Appropriate Claims Administrator** as that term is defined in this Chapter;
- c. **name a specific individual including their social security number, Medicare HICN number or Medicare beneficiary identifier (MBI),**
- d. **name a specific medical condition or symptom,**
- e. **name a specific treatment, service or product** for which approval or payment is requested,
- f. **made in accordance with the Plan's claims filing procedures described in this Chapter;** and
- g. **includes all information required by the Plan and its Appropriate Claims Administrator, such as the existence of additional health coverage that would assist the Plan in coordinating benefits.**

A claim is NOT:

- a. a request made by **someone other than** the individual or their Authorized Representative;
- b. a request made by a **person who will not identify** themselves (anonymous);
- c. a **casual inquiry about benefits** such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
- d. a request for **prior approval of Plan benefits where prior approval is not required** by the Plan;
- e. an **eligibility inquiry that does not request Plan benefits**. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an Adverse Benefit Determination and the individual will be notified of the decision and allowed to file an appeal;
- f. a **request for services and claims for a work-related injury/illness**, unless the Workers' Compensation program has provided a written confirmation that the injury/illness is not compensable as a work-related claim.
- g. a **submission of a prescription** with a subsequent Adverse Benefit Determination at the point of sale at a retail pharmacy or from a mail order service.

Concurrent Care Claim: A concurrent care claim refers to a Plan decision to reduce or terminate a pre-approved ongoing course of treatment before the end of the approved treatment. A concurrent care claim also refers to a request by you to extend a pre-approved course of treatment. Individuals will be given the opportunity to argue in favor of uninterrupted continuity of care before treatment is cut short.

Days: For the purpose of the claim filing and appeal procedures outlined in this Chapter, “days” refers to calendar days, not business days.

Disability Claim: A disability claim is a claim for long term disability (LTD) benefits under the Plan to which the Plan conditions the availability of the benefit on proof of a claimant’s disability (See also Chapter 10). A claim regarding rescission of disability coverage will be treated as a disability claim unless related to failure to pay premiums/contributions for disability coverage.

Health Care Professional: Means a Physician or other Health Care Professional licensed, accredited or certified to perform specified health services consistent with State law.

Independent Review Organization or IRO: Means a private accredited entity that conducts independent external review of Adverse Benefit Determinations in accordance with the Plan’s external review provisions and current federal external review regulations. The Plan contracts with, and rotates cases between, at least three IROs.

Post-Service Claim: A post-service claim is a claim for benefits under the Plan that is not a pre-service claim. Post-service claims are claims that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim and an electronic bill, submitted for payment after services have been provided, are examples of post-service claims. A claim regarding rescission of coverage will be treated as a post-service claim.

Pre-Service Claim: A pre-service claim is a request for benefits under this group health Plan where the Plan conditions payment, in whole or in part, on the approval of the benefit in advance of obtaining health care. The services that require preauthorization are listed in Chapter 4 in this document. The Plan Administrator may determine, in its sole discretion, to pay benefits for the services needing preauthorization (that were obtained without prior approval) if the patient was unable to obtain prior approval because circumstances existed that made obtaining such prior approval impossible, or application of the pre-service (preauthorization) procedure could have seriously jeopardized the patient’s life or health.

Rescission: Means a cancellation or discontinuance of coverage including coverage for disability benefits that has a retroactive effect, except to the extent it is attributable to failure to timely pay required contributions or self-payments. The Plan is permitted to rescind your coverage if you perform an act, practice or omission that constitutes fraud or you make an intentional misrepresentation of material fact that is prohibited by the terms of this Plan (see also Chapter 3).

Tolled: Means stopped or suspended, particularly as it refers to time periods during the claims process.

Urgent Care Claim: An urgent care claim is a claim (request) for medical care or treatment in which applying the time periods for precertification/preauthorization, as determined by your Health Care Professional:

- could seriously jeopardize the life or health of the individual or the individual’s ability to regain maximum function, or
- in the opinion of a Physician with knowledge of the individual’s medical condition, would subject the individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, or is a claim involving urgent care.

The services that require preauthorization are listed in Chapter 4.

Review Of Issues That Are Not A Claim As Defined In This Chapter

A Plan participant may request review of an issue (that is not a claim as defined in this Chapter) by writing to the Board of Trustees whose contact information is listed on the Quick Reference Chart in this document. The request will be reviewed and the participant will be advised of the decision within the timeframes applicable to post-service claims.

Anthem Medical PPO Plan

Discussed below are the various types of claims associated with Plan benefits, procedures for filing claims, and the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal the decision. The times mentioned in the discussion are summarized in the charts at the end of the discussion.

Filing A Claim

Filing a Claim: Unless otherwise indicated, in order to receive Anthem Medical PPO Plan benefits, you, or your medical services provider, must file a written claim with the Claims Administrator. Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims.

Information on how to file pre-service claims is included under the “Preauthorization” section in Chapter 4. Information on how to file other types of claims is included at the end of each of the Chapters describing the individual benefits earlier in this booklet. Here is a brief summary of the information presented there:

- **Pre-service claims for health care benefits (including urgent and concurrent claims):** You or your provider may telephone Anthem to request preauthorization. Alternatively, you may complete a Preauthorization Request form (available from the Claims Administrator) and send or hand-deliver the completed form to the Claims Administrator at the following address:
Anthem Blue Cross/Preauthorization Department
2000 Corporate Center Drive CANPA-000
Newbury Park, CA 91320
- **Post-service claims for Anthem Medical PPO Plan benefits:** Post-service claims for health care benefits other than outpatient Prescription Drugs should be sent to the following address:
Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007
- **Post-service claims for Medical HMO Plan benefits:** There is no need to initiate a claim if you receive medical services at a Kaiser Permanente facility from a Kaiser Plan provider. See the Post-Service Claims and Appeals section of your Kaiser Explanation of Coverage for how to file a claim for reimbursement for health care benefits that were not rendered at a Kaiser facility or from a non-Kaiser Plan provider.
- **Post-service claims for outpatient Prescription Drug benefits related to retail, mail order and specialty Drugs under the Anthem Medical PPO Plan:** Refer to the Drug row of the Schedule of Medical Benefits for information on obtaining outpatient Drugs from network locations and Drug reimbursement under the Direct Member Reimbursement provision for use of a non-network location.

- **Long Term Disability (LTD) benefit claims:** In the event that you become disabled, notify the Administrative Office of this fact at once (contact information is listed on the Quick Reference Chart at the front of this document). The Administrative Office will let you know what information is required to establish the disabled status. See also Chapter 10.
- **Life Insurance or Accidental Death and Dismemberment (AD&D) claims:** To initiate a claim for life insurance, you or your beneficiary should send a certified copy of the death certificate carrying the deceased's Social Security number to the Administrative Office at:

Southwest Carpenters Health and Welfare Trust
P.O. Box 17969
Los Angeles, California 90017-0969

To initiate a claim for accidental death and dismemberment insurance, you or your beneficiary should notify the Administrative Office of the loss as soon as possible. The necessary forms will then be sent to the claimant. The Administrative Office works with the Life and AD&D Insurance Company.

- **Dental claims:** There is no need to initiate a claim if you receive dental services from an approved network Dentist from the list of Dentists maintained by your dental insurance carrier. You will receive an explanation of benefits (EOB) report through the mail, which provides payment information about the services you received from your Dentist.

If you use a non-network (out-of-network) provider for covered dental services, you pay for the service and later can submit your claim for reimbursement following the procedures outlined in Chapter 7.

Contact your dental plan directly if you have questions about a denial of dental services or claims. See the contact information on the Quick Reference Chart at the front of this document. If you wish to submit a complaint or grievance, you may find the appropriate form online at <https://www.myuhcdental.com/presence/release/membersgrievanceform.asp>.

- **Vision Claims:** There is no need to initiate a claim if you receive vision services from an approved network optometrist from the list of optometrists maintained by your vision plan. You may receive an explanation of benefits (EOB) report through the mail which provides payment information about the vision services you received.

If you use a non-network (out-of-network) provider for covered vision services, you pay for the service and later can submit your claim for reimbursement following the procedures outlined in Chapter 8.

Contact your vision plan directly if you have questions about a denial of vision services or claims. For questions relating to UnitedHealthcare Vision Plan services, call toll-free at 800-638-3120, or visit their website at www.myuhcvision.com.

Expenses Incurred Outside the United States

Charges for health care expenses incurred outside the United States are not covered unless they are for Emergency care you receive while traveling on business or vacation (attending school outside the United States does not qualify as traveling on business or vacation).

If an Eligible Individual incurs Allowable Charges for Emergency health care outside the United States while traveling on business or vacation and pays the provider at that time, and if the provider's charge is \$50 or more, payment must be made by check, money order or credit card voucher (not cash) in order for the individual to receive reimbursement from this Plan.

A copy of your cancelled check, money order or credit card voucher and an itemized bill must be

included with the claim along with the regular filing requirements when you submit it to the Claims Administrator for reimbursement. An itemized billing is required for any claim incurred outside the United States.

For claims incurred outside the U.S. (foreign claims), in most cases you will have to pay the provider at the time of service. Then at a later date you can submit the foreign claim and your proof of payment to this Plan for consideration of reimbursement in accordance with Plan rules outlined in this document.

- If the provider located outside the U.S. does not require payment at the time of service, when such claims are determined to be payable by this Plan, payment for covered services will be sent to the Plan participant.
- Foreign claims will be processed like any other non-network claim.
- The claims administrator will have the claim translated into English and then will determine the daily rate of exchange between the U.S. dollar and the applicable foreign currency (based on the rate of exchange quoted on www.oanda.com on the date when the treatment or services were received).
- Then payment will be made to you so that you can forward payment to the appropriate provider outside the U.S.
- Payment is not made by this Plan to a provider outside the U.S.

When Claims Must Be Filed - Anthem Medical PPO Plan

If you receive services from Non-Network Providers, you may be required to file a claim for benefits yourself with the Claims Administrator (Anthem Blue Cross) and include a completed claim form. A standard claim form is available from the Administrative Office or from the Plan's website at www.carpenterssw.org. In-Network Providers will generally submit claims on your behalf and no claim form is needed.

Your claim will be considered to have been filed as soon as it is received by the Administrative Office or Claims Administrator.

Pre-service and Urgent Care Claims must be filed **before services are obtained**. If you improperly file a pre-service claim, the Claims Administrator will notify you as soon as possible but not later than **5 days** after receipt of the claim, of the proper procedures to be followed in filing a claim.

You will receive notice of an improperly filed pre-service claim only if the claim includes your name, your specific health condition or symptom and a specific treatment, service or product for which approval is requested. Unless the claim is re-filed properly, it will not constitute a claim.

Concurrent care claims must be filed before the end of the approved treatment.

You must **submit all post-service claims within 90 days** following the date the charges were incurred. Failure to file claims within the time required will not invalidate or reduce any claim if it was not reasonably possible to file the claim within such time. However, in that case, the claim must be submitted as soon as reasonably possible **and in no event later than 15 months from the date the charges were incurred**.

No Plan benefits will be paid for any claim submitted after this 15 month period.

Early retirement pensioners must submit their application (including a copy of their Social Security disability award) for Supplemental Long Term Monthly Disability Benefits to the Administrative Office **within 90 days of the date of their Social Security disability award.**

Proof Needed In Order to Process Claims:

- a. When processing claims submitted on behalf of a **Newborn Dependent Child** the Appropriate Claims Administrator must receive confirmation of the child's eligibility for coverage from the Administrative Office.
- b. When processing claims submitted on behalf of a **Dependent Child who is age 26 or older**, the Appropriate Claims Administrator must receive confirmation of the child's eligibility from the Administrative Office.
- c. If claims are submitted on behalf of a **Dependent child for whom the Plan has not yet received proof of Dependent status**, the Appropriate Claims Administrator must receive the proof of eligibility from the Administrative Office before the claim can be considered for payment.
- d. When processing claims submitted on behalf of a **new Spouse**, the Appropriate Claims Administrator must receive confirmation of the Spouse's eligibility from the Administrative Office.
- e. When processing **claims related to an accident** the Appropriate Claims Administrator will need information about the details of the accident in order to consider the claim for payment.
- f. See Chapter 10 for information needed for **proof of a disability claim.**

Timing of Initial Claims Decisions - Anthem Medical PPO Plan

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

Pre-service claims: If your pre-service claim has been properly filed, the Appropriate Claims Administrator will notify you of its decision within **15 days** from the date your claim is filed, unless additional time is needed.

- The time for response may be extended up to **15 days** if necessary due to matters beyond the control of the Appropriate Claims Administrator. If an extension is necessary, you will be notified before the end of the initial 15-day period of the circumstances requiring the extension and the date by which the Claims Administrator expects to make a decision.
- If an extension is needed because the Appropriate Claims Administrator needs additional information from you, the Appropriate Claims Administrator will notify you as soon as possible, but no later than **15 days** after receipt of the claim, of the specific information necessary to complete the claim. In that case you will have **45 days** from receipt of the notification to respond, or the claim will then be deemed denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days have passed or the date you respond to the request (whichever is earlier).
- Upon submission of the necessary information, the Appropriate Claims Administrator then has **15 days** to make a decision and notify you of the determination.

Urgent care claims: A benefit determination (whether adverse or not) with respect to a claim involving urgent care will be made as soon as possible, taking into account the medical urgency, but not later than **72 hours** after the receipt of the urgent care claim by the Plan or issuer.

Concurrent care decision: In the event the Plan has approved an ongoing course of treatment to be provided over a period of time or a number of treatments and a determination is made by the Plan to reduce or terminate such course of treatment or the number of treatments (other than by Plan amendment or termination), you will be notified as soon as possible, but in any event early enough to allow you to file an appeal and to have that appeal decided **before the benefit is reduced or terminated**.

Post-service claims: Ordinarily, you will be notified of the decision on your post-service claim within **30 days** of the date the Appropriate Claims Administrator receives the claim.

- This period may be extended one time for up to **15 days** if the extension is necessary due to matters beyond the control of the Appropriate Claims Administrator. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension and the date by which the Appropriate Claims Administrator expects to make a decision.
- If an extension is needed because the Appropriate Claims Administrator needs additional information from you, the Appropriate Claims Administrator will notify you as soon as possible, but no later than **30 days** after receipt of the claim, of the specific information necessary to complete the claim. You and/or your doctor or Dentist (or pharmacist, for claims sent to the PBM) will have **45 days** from receipt of the notification to respond or the claim will then be deemed denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended.
- The deadline is suspended from the date of the extension notice until either 45 days have passed or the date you respond to the request (whichever is earlier). The Appropriate Claims Administrator then has **15 days** to make a decision on your post-service claim and notify you of the determination.

Claims for Long-Term Disability (LTD) benefits: The Administrative Office will ordinarily make a decision on the claim and notify you of the decision within **45 days** of receipt of the disability claim.

- This period may be extended by up to **30 days** if the extension is necessary due to matters beyond the control of the Administrative Office. If an extension is necessary, you will be notified before the end of the initial 45-day period of the circumstances requiring the extension and the date by which the Administrative Office expects to make a decision. The notice of extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues.
- A decision will then be made within **30 days** of when the Administrative Office notifies you of the delay. The period for making a decision may be extended an additional **30 days**, provided the Administrative Office notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Administrative Office expects to render a decision.
- If an extension is needed because the Administrative Office needs additional information from you, the Administrative Office will notify you as soon as possible, but no later than **45 days** after receipt of the claim, of the specific information necessary to complete the claim. You will have **45 days** from receipt of the notification to respond or the claim will then be deemed denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days have passed or the date you respond to the request (whichever is earlier).
- The Administrative Office then has **30 days** to make a decision on your claim and notify you of

the determination.

Life insurance and accidental death and dismemberment claims: The insurance company will ordinarily make a decision on a claim for life insurance or accidental death and dismemberment benefits within **90 days** of receipt of the claim. This period may be extended by up to **90 days** if the extension is necessary due to matters beyond the control of the insurance company. If an extension is necessary, you will be notified before the end of the initial 90-day period of the circumstances requiring the extension and the date by which the insurance company expects to make a decision.

Denied Claims (Initial Adverse Benefit Determinations)

Whenever your claim is denied in whole or in part, you will be provided notice of the Adverse Benefit Determination. The notice will either be in the form of correspondence or in the form of an Explanation of Benefits (EOB) form from the Appropriate Claims Administrator.

Adverse Benefit Determinations involving Urgent Care Claims may be provided to the claimant orally and written notification will also be furnished to the claimant not later than 3 days after the oral notification.

An **Adverse Benefit Determination notice will include** the following:

- a. information sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
- b. a statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review (when external review is applicable);
- c. the specific reason(s) for the determination, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim,
- d. **for disability claims**, give the specific reason(s) for the denial of disability benefits (including a discussion of the decisions and the basis for disagreeing with or not following the (1) views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professional who evaluated the claimant, (2) views presented by the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, and (3) the claimant's disability determination made by the Social Security Administration that was presented by the claimant to the Plan);
- e. reference to the specific Plan provision(s) on which the determination is based,
- f. a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
- g. a description of any additional material or information necessary if you want a further review of the claim and an explanation of why the material or information is necessary,
- h. an explanation of the Plan's 1st level appeal and where applicable the 2nd level appeal and the external review process (when external review is applicable), along with any time limits and information regarding how to initiate the next level of review,
- i. a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse appeal determination,
- j. if an internal rule, guideline, protocol or other similar criterion was relied upon in deciding your claim, either a copy of the rule, guideline, protocol or other similar criterion or a statement that it was relied upon in deciding your claim and that it is available upon request at no charge,

- k. if the determination was based on not being Medically Necessary or the treatment's being Experimental or Investigational or other similar exclusion, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge, and
- l. disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes (when external review is applicable).
- m. if you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart for contact information) to find out if assistance is available.
 - SPANISH (Español): Para obtener asistencia en Español, llame al Anthem (833) 224-6930.
 - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa Anthem (833) 224-6930.
 - CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 Anthem (833) 224-6930.
 - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' Anthem (833) 224-6930.

For pre-service claims, you will receive notice of the determination orally or in writing even when the claim is approved. If the Adverse Benefit Determination concerns an Urgent Care Claim, the notice will contain a description of the expedited review process applicable to such claims.

Claim Appeal for the Anthem Medical PPO Plan and for Eligibility Issues

Appeal of an Adverse Benefit Determination: The Claim Appeal Process

If your claim is denied in whole or in part or you disagree with the decision made on a claim, you may ask for a review (appeal the decision). For information on the type of claim, the options for appeals and who administers the appeals, see the chart on page 152 for the definition of Appropriate Claims Administrator.

Appeals must be submitted in writing to the Appropriate Claims Administrator. You must exhaust both the Plan's internal appeal process outlined in this Chapter before filing a civil action under ERISA Section 502(a) following an adverse appeal determination.

Your request for a **first level appeal** must be made in writing to the Appropriate Claims Administrator as follows:

- to the **Appropriate Claims Administrator** within **180 days** after you receive the notice of denial for a claim involving health care (or, in the case of a concurrent care decision, within a reasonable time, given the medical urgency of your situation).
- to the **Administrative Office** within **180 days** after you receive an adverse benefit determination on a claim for long term disability benefits.
- to the **Life Insurance Company** within **60 days** after you receive the notice of denial for life insurance or accidental death and dismemberment claims.

Note Regarding Urgent Care Claims: Appeals involving an Urgent Care Claim must be submitted within 180 days after the Adverse Benefit Determination is made. Appeals of claims that involved an Urgent Care Claim will not automatically be deemed to involve an Urgent Care Claim, but the Health Care Professional must indicate that the urgency continues to exist. Appeals involving an Urgent Care Claim may be submitted by telephone to the Appropriate Claims Administrator.

If the type of claim is eligible for a second-level appeal, the Benefits Committee of the Board of Trustees will decide all second-level appeals. The Benefits Committee has full discretionary authority to determine all questions of eligibility for benefits, including the discretionary authority to make all factual determinations and to construe any terms of the Plan.

Appeal Review Process

All appeals will be reviewed and decided by the Appropriate Claims Administrator which is in certain cases, the Benefits Committee of the Board of Trustees of the Southwest Carpenters Health and Welfare Trust. (See page 152 and page 171 for a chart outlining the appeals process.) The Benefits Committee has full discretionary authority to determine all questions of eligibility for benefits, including the discretionary authority to make all factual determinations and to construe any terms of the Plan. **When a second-level appeal applies, the Benefits Committee will decide all second-level appeals.**

For all appeals, claimants may submit written comments, documents, records, and other information relating to the claim for benefits.

For all appeals, claimants will be provided, 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. A document, record, or other information is relevant to a claim if it:

- a. Was relied on in making the benefit determination;
- b. Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether it was relied upon in making the benefit determination;
- c. Demonstrates compliance with the Plan's administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing Plan documents and that, where appropriate, Plan provisions have been applied consistently with respect to similarly situated claimants; or
- d. Constitutes a statement of policy or guidance with respect to the Plan concerning any denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

The Plan's full and fair review of all appeals will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The claimant will be provided automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.

If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

Review of all appeals, other than appeals concerning claims for life insurance or AD&D benefits, will afford no deference to the initial adverse benefit determination (or to the previous appeal decision, in

the case of a second level appeal).

No appeal decision will be made by the individual who made the Adverse Benefit Determination that is the subject of the appeal (or by any individual who decided a previous level of appeal), or by a subordinate of any such individual.

In all appeals, except appeals concerning claims for life insurance or AD&D benefits, if the adverse benefit determination was based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, Drug, or other item is Experimental, Investigational, or not Medically Necessary, the appropriate named fiduciary handling the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional engaged for the purpose of providing this medical review will not be the individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the review (or who was consulted in connection with a prior level of review), nor the subordinate of any such individual.

In all appeals, except appeals concerning claims for life insurance or AD&D benefits, the claimant will be provided, upon request and free of charge, with notice of the identity of any medical or vocational experts whose advice was obtained in connection with the claimant's Adverse Benefit Determination (or in connection with any prior level of review), without regard to whether the advice was relied upon in making the benefit determination.

Time Frames for Notice of Decision on Appeal

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

- **Pre-service claims:** You will be sent a notice of a decision on the appeal review within **15 days** of receipt of the appeal by the Claims Administrator.
- **Urgent care claims:** You or your representative will be notified of the determination on appeal review **as soon as possible but no later than 72 hours after receipt of the appeal.**
- **Concurrent care decisions:** You will receive notice of a decision on appeal review **before reduction or termination** of a treatment in progress.
- **Post-service claims:** Ordinarily, decisions on **first-level appeals** involving post-service Anthem Medical PPO Plan claims will be made by the Claims Administrator within **30 days** after receipt of the appeal.

Decisions on **second-level appeals** to the Benefits Committee will ordinarily be decided at the next regularly scheduled quarterly **meeting** of the Benefits Committee of the Board of Trustees following receipt of your request for review. However, if your request for review is **received within 30 days** of the next regularly scheduled meeting, your request for review may be considered at the second regularly scheduled meeting of the Benefits Committee following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary.

Once a decision on review of your claim appeal has been reached, you will be notified of the decision as soon as possible, but **no later than 5 days** after the decision has been reached.

- **Claims for long-term disability (LTD) benefits:** Timing and procedures for initial claim determinations involving disability claims are described earlier in this Chapter in the subsection titled “Claims for Long-Term Disability (LTD) benefits.” Appeal of a denial of an LTD benefit is decided by the Benefits Committee and the process is described below in this Chapter and in the chart titled “Maximum Times for Processing of Disability Claims” in this Chapter.
- **Life insurance or accidental death and dismemberment claims:** Decisions will ordinarily be made within **60 days** of receipt of an appeal by the Life Insurance Company. The period for making a decision may be extended by up to **60 days**, provided the Life Insurance Company notifies you, prior to the expiration of the first 60 days, of the circumstances requiring the extension and the date as of which the Life Insurance Company expects to render a decision.

The decision on any appeal review of your claim will be given to you in writing. The written notice of the appeal decision will contain the following:

- a. Information sufficient to identify the claim involved (including the date of service, the health care Provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- b. The statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for a 2nd level of appeal or external review (when external review is applicable);
- c. **For disability claims**, give the specific reason(s) for the denial of disability benefits (including a discussion of the decisions and the basis for disagreeing with or not following the (1) views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professional who evaluated the claimant, (2) views presented by the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant’s adverse benefit determination, and (3) the claimant’s disability determination made by the Social Security Administration that was presented by the claimant to the Plan);
- d. Whether, and the extent to which, the original Adverse Benefit Determination is upheld or reversed;
- e. A discussion of (reason for) the decision;
- f. If the Adverse Benefit Determination is upheld, in whole or in part, the notice will state the specific reason or reasons for the adverse determination including the denial code and its corresponding meaning;
- g. Reference to the specific Plan provisions on which the benefit determination is based;
- h. 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; (Whether a document, record, or other information is found to be relevant);
- i. A description of available external review processes, including how to initiate an external review (when applicable) along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;
- j. The availability of, and contact information for, any applicable office of health insurance consumer assistance to assist individuals with the internal claims and appeals and external review processes;
- k. A statement of the claimant’s right to bring an action under section 502(a) of ERISA following exhaustion of administrative remedies;

- l. If the original Adverse Benefit Determination is upheld, in whole or in part, the notice will state whether an internal rule, guideline, protocol, or other similar criterion was relied upon in making any adverse determination, and if so, either the specific rule, guideline, protocol, or other similar criterion, or a statement that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request; and
- m. If the original Adverse Benefit Determination is upheld, in whole or in part, and if the Adverse Benefit Determination is based on a Medical Necessity or Experimental treatment or similar exclusion or limit, the notice will contain an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances.
- n. The decision of the Benefits Committee is the final internal Adverse Benefit Determination and is binding on the Plan.
- o. Following a final internal Adverse Benefit Determination, if the claimant continues to believe that the decision is contrary to the terms of the Plan, the claimant has the right to request an external review or bring civil action challenging the decision under section 502(a) of ERISA, 29 U.S.C. §1132(a). However, no legal or equitable action for benefits under the Plan may be brought unless and until the final internal Adverse Benefit Determination has been completed and a decision rendered. Any suit or claim must be **filed within 1 year** of the decision of the Benefits Committee. Any legal action filed under ERISA § 502(a) against the Fund or Plan by an Employee, Participant or beneficiary may only be brought in Federal District Court in Los Angeles County, California.
- p. If the Plan fails to strictly adhere to all of the above requirements, the claimant is deemed to have exhausted the internal claims and appeals process. The claimant can then pursue an external review or sue under section 502(a) of ERISA on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim. If a claimant chooses to sue under 502(a) the claim or appeal is deemed denied on review without exercise of discretion by an appropriate fiduciary. However, the claimant will not be deemed to have exhausted the internal claims and appeals process if the failure to strictly adhere to all of the requirements are de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant.
- q. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart for contact information) to find out if assistance is available.
 - SPANISH (Español): Para obtener asistencia en Español, llame al Anthem (833) 224-6930.
 - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa Anthem (833) 224-6930.
 - CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 Anthem (833) 224-6930.
 - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' Anthem (833) 224-6930.

See also the charts that summarize the appeal process and timing located on page 152.

Voluntary External Review Of A Denied Claim

External Review of Denied Claims

You may request an external review, by an Independent Review Organization (“IRO”), in the situation where your appeal of a health care claim, whether urgent, concurrent, pre-service or post-service claim is denied and it fits within the following parameters:

- a. The denial involves medical judgment, including but not limited to, those based on the Plan’s requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, an adverse determination related to coverage of routine costs in a clinical trial, or a determination that a treatment is Experimental or Investigational. The IRO will determine whether a denial involves a medical judgment; or medical judgment for determinations of whether a plan is complying with the non-quantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act, and/or
- b. The denial is due to a Rescission of coverage (retroactive elimination of coverage), regardless of whether the Rescission has any effect on any particular benefit at that time.

This External Review process is not available for any other types of denials, including life insurance, disability benefits, dental, or vision coverage or if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan. The Plan assumes responsibility for fees associated with External Reviews discussed in this Chapter.

(Contact the Administrative Office to discuss the availability of an Independent Review related to the Long Term Disability - LTD benefit. Note, members pay part of the cost associated with an Independent Review under the LTD benefit as described in Chapter 10.)

Generally, you may only request external review after you have exhausted the internal claims and appeals process described above. This means that, in the normal course, you may only seek external review after a final determination has been made on an appeal. For more information about the External Review procedures, contact the Administrative Office.

There are **two types of External Claims** outlined below: Standard (Non-Urgent) Claims and Expedited Urgent Care Claims.

Time Frame and Procedures for Standard (Non-Urgent) External Review

A request for an external review must be submitted, in writing, by the claimant, their Authorized Representative or In-Network Provider to the Fund **within four (4) months** after the date of receipt of a notice of an Adverse Benefit Determination or final internal Adverse Benefit Determination.

Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether the request is eligible for external review.

- Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant.

If the request is complete and eligible for external review it will be sent to an Independent Review Organization (IRO) for review. The Plan retains at least three IROs from which it can select to perform external reviews. The Plan requires its contracted IROs to maintain written records for at least three years.

If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and contact information for any applicable office of health insurance consumer assistance;

If the request is not complete, the notification will describe the information or materials needed to make the request complete. In addition, the Plan will allow a claimant to perfect the request for external review within the four month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

- The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review.

The notice will include a statement that the claimant may submit in writing to the assigned IRO additional information that the IRO must consider when conducting the external review; however, the additional information must be received within 10 business days following the date of receipt of the notice.

- The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
 - a. The claimant's medical records;
 - b. The attending health care professional's recommendation;
 - c. Reports from the appropriate health care professionals and other documents submitted by the Plan, claimant, or the claimant's treating Provider;
 - d. The terms of the claimant's Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
 - e. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
 - f. Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
 - g. The opinion of the IRO's clinical review or reviewers to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.
- The assigned IRO must provide written notice of the final external review decision **within 45 days** after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the claimant and the Plan.
- The assigned IRO's decision notice will contain:
 - a. 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), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
 - b. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
 - c. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
 - d. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
 - e. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or the claimant;

- f. A statement that judicial review may be available to the claimant; and
 - g. Current contact information, including phone number, for any applicable office of health insurance consumer assistance.
- After a final external review decision, an IRO must make records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where disclosure would violate State or Federal privacy laws.
 - Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Time Frame and Procedures for Expedited External Review

A claimant may request an expedited external review with the Plan at the time the claimant receives:

- An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has requested a request for an expedited internal appeal; or
- A final internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received Emergency Services, but has not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the Plan must determine whether the request meets the reviewability requirements for standard external review. The Plan must immediately send a notice to the claimant of its eligibility determination.

Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO. The Plan must provide all necessary documents to the assigned IRO as expeditiously as possible.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents submitted. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The assigned IRO must provide notice of the final external review decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the Plan.

Appeals of Adverse Benefit Determinations Made by Third Party Vendors (Appropriate Claims Administrators)

A claimant has a right to request a review of any benefits administered by any third party vendor that makes adverse benefit determinations, which may include third party administrators of insured benefits such as: the HMO medical plan, the dental benefits administrator, vision benefits administrator, life insurance and/or AD&D vendors. As to all such insured benefits administered by any third party vendor making any adverse benefit determination, the claimant's right to request a review will be determined under the agreement between the Southwest Carpenters Health and Welfare Trust and the third party vendor, which decision shall comply with all applicable law.

If a claimant disagrees with the appeal decision of the vendor, the claimant may file a second level of appeal to the Health and Welfare Fund's Benefits Committee **but only as to self-funded medical claims administered by Anthem Blue Cross and self-funded Prescription Drug claims administered by Express Scripts.**

- Second-level appeals must be filed with the Administrative Office within 60 days after the claimant receives notification of the decision on the first-level appeal. In order to exhaust the claimant's administrative remedies, the claimant must file a second-level appeal.
- The Appeals Committee will make a decision on the second-level appeal of an adverse benefit determination within the timeframes specified above. See the section above called "Time Frames for Notice of Decision on Appeal."

There is no first-level or second-level appeal to the Southwest Carpenters Health and Welfare Trust's Benefits Committee for claims regarding the following **insured benefits**: HMO Medical Plan, dental, vision, life insurance, and accidental death and dismemberment coverage. For these insured benefits, appeals will be handled by the insurance carrier according to the procedures specified in the carrier's Disclosure Form/Evidence of Coverage booklets, copies of which may be obtained from the website of the Carpenters Southwest Administrative Corporation at www.carpenterssw.org.

Following the exhaustion of the internal appeal procedure, if the claimant continues to believe that the decision is contrary to the terms of the Plan, the claimant has a right to request an external review or bring a legal or equitable action for benefits under Section 502(a) of ERISA.

No action for benefits may be brought against the Plan unless and until the Plan's second-level internal appeal has been completed and a decision rendered.

Any suit or claim must be filed **within one (1) year** of the decision of the Benefits Committee.

If the Plan fails to strictly adhere to all the foregoing appeals requirements, the claimant is deemed to have exhausted the internal claims and appeals process. The claimant can then pursue an external review or sue under 502(a) of ERISA on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

If a claimant chooses to sue under 502(a) the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary. However, the claimant will not be deemed to have exhausted the internal claims and appeals process if the failure to strictly adhere to all of the requirements are de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant.

Summary Of Claim Filing And Claim Appeal Timeframes

Maximum Times for Administrative Processing of Health Care Claims				
	Pre-Service Claims	Urgent Care Claims	Concurrent Care Claims	Post-Service Claims
Appropriate Claims Administrator makes initial determination	Within 15 days of receipt of claim	As expeditiously as possible but no more than 72 hours after receipt of the Urgent Care Claim	Before the benefit is reduced or treatment terminated.	Within 30 days of receipt of claim
Appropriate Claims Administrator notifies you that the claim has been improperly filed.	Within 5 days of receipt of claim	As soon as possible but no later than 24 hours after receipt of the Urgent Care Claim	Before the benefit is reduced or treatment terminated.	Not applicable
Appropriate Claims Administrator requests additional information (an extension)	Yes, one 15 day extension is permitted	As soon as possible but no later than 24 hours after receipt of the Urgent Care Claim	Not applicable	Yes, one 15 day extension is permitted.
You respond to request for information	Within 45 days of request	You will be allowed 48 hours to provide the requested information	Not applicable	Within 45 days of request
Appropriate Claims Administrator makes determination after requesting information	If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed from the date that the Notice was sent to you.	As expeditiously as possible but no more than 48 hours after the earlier of (a) receipt of any additional information or (b) the end of the period afforded for you to provide additional information.	Before the benefit is reduced or treatment terminated.	If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed from the date that the Notice was sent to you.
You make request for a first or second level of appeal	Within 180 days of receiving the initial notice of denial.	Within a reasonable time for your situation.	Within a reasonable time for your situation.	Within 180 days of receiving the initial denial notice or first appeal notice of denial.
Appropriate Claims Administrator makes decision on 1st level appeal	Within 30 days of receiving your request for appeal	Within 72 hours after receipt of the request for appeal.	As soon as possible before the benefit is reduced or treatment terminated.	Within 30 days for the 1 st level of appeal.

Maximum Times for Administrative Processing of Health Care Claims				
	Pre-Service Claims	Urgent Care Claims	Concurrent Care Claims	Post-Service Claims
Board of Trustees/ Committee makes decision on 2nd level appeal	A 2 nd level appeal is not applicable.	A 2 nd level appeal is not applicable.	A 2 nd level appeal is not applicable.	For the 2 nd level appeal: if appeal received 30 or more days from the next Committee meeting then the appeal will be decided at the next regular quarterly Committee meeting or, if appeal is received less than 30 days in advance of the meeting date, at the next subsequent meeting (may be delayed until third such meeting).

Maximum Times for Processing of Disability Claims, and Other Claims Pertaining to Life Insurance and Accidental Death & Dismemberment Claims (Times are suspended pending receipt of additional information requested of you)		
	Disability Claims	Other Claims
Administrative Office/Insurance Company makes initial determination (provided all necessary information is submitted)	Within 45 days of claim's receipt (Up to 2 extensions permitted: can be extended for another 30 days and an additional 30 days after that)	Within 90 days of claim's receipt (can be extended for another 90 days)
Administrative Office/Insurance Company requests additional information	Within 45 days of claim's receipt	Not applicable
You respond to request for information	Within 45 days of request	Not applicable
Plan Benefits Committee/Insurance Company makes determination after requesting additional information	If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed from the date that the Notice was sent to you.	Not applicable
You make request for appeal	Within 180 days of receiving initial notice of denial	Within 60 days of receiving notice of denial
Board Benefits Committee/Insurance Company makes decision on appeal	No later than 5 days after next regular quarterly Benefits Committee meeting or, if appeal is received less than 30 days in advance of the meeting date, at the next subsequent meeting (may be delayed until third such meeting).	Within 60 days of receipt of your request for appeal (can be extended another 60 days)

Important Legal Provisions

Exhaustion of Administrative Remedies and One-Year Time Limitation Upon Bringing a Lawsuit for Plan Benefits Under ERISA

You may not file a lawsuit to claim Plan benefits under ERISA Section 502(a) until you have exhausted all of the Plan's administrative remedies, including the Plan's Claims and Appeals Procedures described above. In the event your claim is denied in the course of your exhaustion of the Plan's administrative remedies set forth in the Plan's Claims and Appeals procedures described above, you must commence any lawsuit under Section 502(a) of ERISA respecting such claim not later than the first anniversary of the date of the written notice of decision on the second appeal denying such claim.

Recovery of Overpayments or Benefits Procured by Dishonesty

The Trust has all available legal and equitable remedies to recover payments to any party in excess of the benefits provided by the Plan or any benefits procured by intentional misstatement of material fact, omission to state a material fact, fraud or other dishonest or tortious conduct, as well as the Trust's costs of recovery including reasonable attorney fees.

Complying With Mental Health Parity And Addiction Equity Act (MHPAEA)

Participants and beneficiaries may request documents and Plan instruments regarding whether the Plan is providing benefits in accordance with Mental Health Parity and Addiction Equity Act (MHPAEA) and copies must be furnished within 30 days of a request. This may include documentation that illustrates how the health Plan has determined that any financial requirement, quantitative treatment limitation, or non-quantitative treatment limitation is in compliance with MHPAEA.

Limitation On When A Lawsuit May Be Started

You or any other claimant may not start a lawsuit or other legal action to obtain Plan benefits, including proceedings before courts or administrative agencies, until after all administrative procedures have been exhausted (including this Plan's claim appeal review procedures described in this document) for every issue deemed relevant by the claimant, or until 90 days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that additional time will be necessary to reach a final decision.

Under this Plan a non-network health care provider/facility is not a claimant that is permitted to start a lawsuit or other legal action to obtain Plan benefits.

The law also permits you to pursue your remedies under Section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them properly.

In addition, you are not required to exhaust external review before seeking judicial remedy.

For disability benefits, no lawsuit may be filed (started) more than **three (3) years** after the start of the disability.

Discretionary Authority Of Plan Administrator And Delegates

In carrying out their respective responsibilities under the Plan, the Plan Administrator or its Delegate, other Plan fiduciaries, and the insurers or administrators of each Program of the Plan, have full discretionary authority to interpret the terms of the Plan, to resolve ambiguities, and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. The Plan Administrator also has the discretion to make all factual determinations arising under the Plan and any claims for benefits thereunder, and applying the facts to the terms of the Plan.

Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Elimination Of Conflict Of Interest

To ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators and medical experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

Facility Of Payment

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

Chapter 16: GLOSSARY OF TERMS

This Chapter includes information on:

- The definition (glossary) of certain terms and words used in this document

The following are definitions of certain terms and words used in this document or that would be helpful in understanding covered or excluded health care services. These definitions do not, and should not be interpreted to, extend coverage under the Plan. Certain definitions pertaining to claims administration and claim appeals are found in the Claim Filing and Claim Appeals Chapter of this document. The definitions are **displayed in alphabetical order** in this Chapter.

Active Carpenter means an employee who is not a Retired Carpenter, and who performs work covered by a Collective Bargaining Agreement. When specified by the Collective Bargaining Agreement, an Active Carpenter also includes an Active Carpenter journeymen and Active Carpenter apprentice. For the purpose of this definition a Retired Carpenter utilizing their Reserve Account (sometimes referred to as their “bank”) for eligibility is considered an Active Carpenter.

Active Rehabilitation means therapy in which a patient, who has the ability to learn and remember, actively participates in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.

Administrative Office means Carpenters Southwest Administrative Corporation office. The main Administrative Office is located at 533 South Fremont Avenue, Los Angeles, California 90071-1706, (213) 386-8590 or (800) 293-1370 and satellite offices may exist from time-to-time that are focused upon the needs of participants working in those areas. “Administrative Office” as used herein includes a Delegate assigned claims administration authority to the degree specified in the Administrative Services Agreement applicable to such Delegate (including the Administrative Services Agreement entered into with Anthem Blue Cross on or after the Effective Date).

Allowed Charge/Allowed Amount/Allowable Charge/Maximum Allowable Fee for the Medical PPO Plan: means the amount this Plan allows as payment for eligible Medically Necessary covered services or supplies. The Allowed Charge amount is determined by the Plan Administrator or its Delegate to be the **lowest** of:

1. **With respect to a Network provider**, Allowed Charge amount means the negotiated fee/rate set forth in the agreement between the participating network Health Care or Dental Care Provider/facility and the network or the Plan; **or**
2. **With respect to a Non-Network provider**, Allowed Charge amount means the schedule that lists the dollar amounts the Plan has determined it will allow for eligible Medically Necessary covered services or supplies performed by Non-Network providers.
3. For a network Health Care Provider/facility whose network contract stipulates that they do not have to accept the network negotiated fee/rate for claims involving a third party payer, including but not limited to auto insurance, workers’ compensation or other individual insurance, or where this Plan may be a secondary payer, the Allowed Charge amount under this Plan is the negotiated fee/rate that would have been payable by the Plan had the claim been processed as a network claim; **or**

4. The **negotiated discounted amount that a non-network provider agreed to**, reducing the provider's original billed charges to a lower, discounted amount; **or**
5. The Health Care or Dental Care Provider's/facility's **actual billed charge**.

A charge is considered to have been incurred on the date on which the service or supply for which charge is made is rendered or obtained.

The Plan will not always pay benefits equal to or based on the Health Care or Dental Care Provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible, Copay and/or Coinsurance. This is because the Plan covers only the "Allowed Charge" amount for health care services or supplies.

The Plan's Allowed Charge amount list is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable charge (UCR), prevailing or any similar term.

The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim.

The Plan reserves the right to negotiate with a non-network provider to reduce their billed charges to a lower, discounted amount. Such negotiation may be performed by the Plan Administrator or its Delegate. A Delegate may include, but is not limited to, a Utilization Management Company, Claims Administrator, attorney, stop loss carrier, medical claim repricing firm, discount negotiation firm or wrap/secondary network. This negotiated discounted amount will become the "Allowed Charge" amount upon which the Plan will base its payment for covered services for the non-network provider considering the Plan's cost-sharing provisions, Network/non-network Plan design, and any Special Reimbursement Provisions adopted by the Plan.

In accordance with federal law, with respect to Emergency Services performed in a Non-Network Emergency Room (ER), the Plan's allowance for ER visit facility fees and ER professional fees is to pay the **greater** of:

- a) the negotiated amount for Network providers (the median amount if more than 1 amount to Network providers), or
- b) 100% of the Plan's usual payment formula (called Allowed Charge in this Plan), reduced for cost-sharing, or
- c) (when such database is available), the amount that Medicare Parts A or B would pay, reduced for cost-sharing.

NOTE: Balance Billing occurs when a healthcare provider bills a patient for charges (other than Copayments, Coinsurance, or Deductibles) that exceed the Plan's payment for a covered service. If you use an out-of-network provider you may be Balance Billed by that provider. Balance Billing might not apply to Emergency Services in a Hospital Emergency room in cases where state law prohibits a person from being required to pay balance-billed charges or where the Plan is contractually responsible for such charges.

Ambulatory Center means a distinct entity that operates exclusively for the purpose of providing outpatient surgical services to patients and which meets all of the following requirements:

- it is operated under the supervision of a Physician,
- it has at least one operating room available for Surgery,
- it has an anesthesiologist or another Physician qualified in resuscitative techniques present or immediately available each day Surgery is performed until all patients who have undergone Surgery for that day are discharged,

- it maintains a clinical record for each patient,
- it has, for patients requiring hospitalization, a written transfer agreement with a Hospital within the proximity of the Ambulatory Center or permits Surgery only by Physicians who have admitting and similar surgical privileges at a Hospital within the proximity of the Ambulatory Center, and
- is licensed as a surgical clinic or similar entity within the state where it is located, or, in the absence of a licensing requirement by the state where it is located, it is accredited by the Accreditation Association for Ambulatory Health Care, Inc.

Anthem Medical PPO Plan means the PPO health care coverage (administered by Anthem) and provided directly by the Trust and described in detail in this booklet (Chapters 4, 5 and 6) which is a medical care option under the Plan. **Outpatient Prescription Drugs under the Anthem Medical PPO Plan** is the outpatient Prescription Drug coverage provided directly by the Trust through a contract with a pharmacy benefit manager (PBM) and described in the Drug row of the Schedule of Medical Benefits in Chapter 5, and which is part of the Anthem Medical PPO Plan.

Appeals Committee means the Benefits Committee of the Board of Trustees that is comprised of members of the Board of Trustees, and appointed by it, which has such authority as the Board from time-to-time allocates to it, with respect to the consideration of the final level of appeals by Eligible Individuals (or former Eligible Individuals) regarding another Delegate's disposition of claims for benefits under the Plan.

Balance Billing/Balance Bill means a bill from a Health Care Provider to a patient for the difference (or balance) between this Plan's Allowed Charges and what the provider actually charged (the billed charges). Balance Billing occurs when a healthcare provider bills a patient for charges (other than Copayments, Coinsurance, or Deductibles) that exceed the Plan's payment for a covered service.

Out-of-Network Health Care Providers commonly engage in Balance Billing. Typically, Network providers do not Balance Bill except in situations of third party liability claims. Generally, you can avoid Balance Billing by using Network providers. Amounts associated with Balance Billing are not covered by this Plan, even if the Plan's annual Out-of-Pocket Limits are reached.

Behavioral Health Care/Psychiatric Care means any treatment, or diagnosis thereof, for any condition or disorder that carries with it a psycho-pathological diagnosis contained in the Diagnostic and Statistical Manual of Mental Disorders (current edition) by the American Psychiatric Association (or any subsequent edition or revision thereof) irrespective of whether it results entirely or in part from one or more congenital, hereditary, biochemical, environmental or other physiological causes. Behavioral Health is an umbrella term that refers to mental health and/or Substance Abuse/Substance Use Disorders.

Board means the Board of Trustees established by the Trust Agreement.

CSAC means the Carpenters Southwest Administrative Corporation.

Calendar Year means January 1 through December 31 of each year.

Certified Nurse-Midwife means a Registered Nurse who has gained the special knowledge and skills of midwifery in an educational program accredited by the American College of Nurse-Midwives and who is licensed in the State in which they practice by the Board of Registered Nursing as Nurse-Midwife.

COBRA means the Consolidated Omnibus Budget Reconciliation Act.

Coinsurance means the percentage of covered health care expenses that an Eligible Individual is responsible to pay.

Collective Bargaining Agreement means

- the Master Labor Agreement or another agreement between the Union and a Contributing Employer (either directly or by reason of such Contributing Employer's membership in an employer association having an agreement with the Union) which covers work performed by an Active Carpenter for such Contributing Employer and which obligates such Contributing Employer to contribute to the Trust with respect to such work (or otherwise obligates such Contributing Employer with respect to such work) in a manner substantially identical to the obligations imposed with respect to the Trust upon employers who are bound to the Master Labor Agreement, or
- an In-Lieu Agreement, or
- any extension, modification, renewal, substitute or successor to an agreement described in the above two clauses of this definition.

Contributing Employer means

- an employer who is obligated to the Trust pursuant to a Collective Bargaining Agreement, or
- an employer who has agreed to contribute to the Trust to provide coverage under the Plan for one or more classes of Special Class employees.

Copayment means the flat dollar amount an Eligible Individual is responsible to pay.

Corrective Appliances: The general term for appliances or devices that support a weakened body part (Orthotic) or replace a missing body part (Prosthetic).

Cosmetic/Cosmetic Surgery or Treatment means **Surgery** or medical treatment solely or primarily to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to, removal of tattoos, breast augmentation except as required by the Women's Health and Cancer Rights Act (WHCRA), or other medical, dental or surgical treatment intended to restore or improve physical appearance, as determined by the Board or its Delegate.

Covered Entity has the meaning set forth at 45 C.F.R. § 160.103 and include a health plan such as the Trust.

Covered Functions has the meaning set forth at 45 C.F.R. § 164.103 and include those functions of a Covered Entity the performance of which makes the entity a "health plan," "health care provider," or "health care clearinghouse" as those terms are defined at 45 C.F.R. § 160.103.

Custodial Care means care rendered to an Eligible Individual who

- is mentally or physically disabled and such disability is expected to continue and be prolonged, and
- requires a protected, monitored or controlled environment whether in an institution or in the home, and
- requires assistance to support the essentials of daily living, and
- is not under active or specific medical, surgical or mental health/Substance Abuse treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored or controlled environment.

This specific definition is found in the federal Dependents' Medical Care Act, and in regulations implementing that Act and the definition of Custodial care, as of the Effective Date of the SPD/Plan Document restatement. These authorities provide further guidance as to the meaning of Custodial care for Plan purposes.

Deductible/Deductible Amount means the portion of the cost for Allowable Charges that must be

borne by an Eligible Individual before the Plan begins to pay toward covered services.

Delegate means a subcommittee of the Board, or other person or entity to whom the Board, by this Plan, or by written resolution adopted in accordance with Article VI of the Trust Agreement, or by execution of an administrative agreement for claims processing (including the most current Administrative Services Agreement with Anthem Blue Cross for medical claims processing for this Plan), or longstanding practice, has been delegated a portion of its discretionary authority with respect to the administration of the Plan, and will include, without limitation, the Administrative Office, the Benefits Committee and includes an insurer, health maintenance organization, managed care organization, or similar entity (other than a PBM that has not acknowledged fiduciary status) which agrees to provide certain of the benefits under the Plan.

Dental DC Plan Option means insured dental care coverage called Direct Compensation (DC) by an insurance company under contract to the Plan.

Dental In-Network Only Plan (INO) means an insured In-network Only (INO) Dental Plan design by an insurance company under contract to the Plan.

Dentist means a Dentist acting within the scope of the Dentist's license, holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) and who is legally entitled to practice Dentistry under the laws of the state or jurisdiction where the services are rendered.

Dependent

a. **In General** – Subject to the conditions, limitations, and requirements set forth in items (b) and (c) below, a Dependent of an Active Carpenter or Special Class Employee means the following individuals:

- **A lawful Spouse.** A Spouse that is legally married is eligible. A Spouse that is legally separated from the Active Carpenter or Special Class Employee is not eligible. See also the definition of Spouse in this Glossary Chapter.
- **A Dependent Child (other than for life insurance and other non-health benefits)** who is married or unmarried through the last day of the month in which such Dependent Child attains at 26 years. (See subsection “c” below regarding eligibility for Dependent children to age 19 or 23 for the life insurance and other non-health benefits.) Dependent Child means an Active Carpenter's or Special Class Employee's:
 - **Natural child,**
 - **Stepchild** (for purposes of this Plan, the term “stepchild” will only include children of the Active Carpenter's or Special Class Employee's lawful Spouse),
 - **Child who is legally adopted** or placed for adoption with an Active Carpenter or Special Class Employee prior to the age of 18 evidenced by a domestically enforceable court order providing for the legal adoption of the child where the meaning of such order is that the Active Carpenter or Special Class Employee has legal responsibility for custody and maintenance of the child. A Dependent Child “place for adoption” means an individual, who is less than 18 years of age, for whom the Active Carpenter or Special Class Employee has assumed, and continues to retain, a legal obligation for total or partial support in anticipation of adoption of such person,
 - Child for whom the Active Carpenter or Special Class Employee or their Spouse is the **court appointed Legal Guardian** prior to the age of 18 and has a domestically enforceable court order granting Legal Guardianship for the child where the meaning of such order is that the Active Carpenter or Special Class Employee has a legal responsibility for custody and maintenance of the child. The child must be eligible for tax-free health coverage as a “qualifying child” or “qualifying relative” under the

applicable requirements of Internal Revenue section 152(c) or 151(d), respectively. In the event the Administrative Office determines in its complete discretion that it can satisfy tax information reporting requirements acting alone without a withholding obligation other than one on the Contributing Employer, on an administratively feasible basis, it may waive the limitation of the preceding sentence. **Legal Guardian means** a person recognized by a U.S. court of law as having the duty of taking care of a minor child and managing the property and rights of such minor child.

Other Dependent Children include:

- 1) **Adult Disabled Child:** An unmarried Dependent Child who, on the last day of the month in which such Dependent Child attains age 26 and continuously thereafter, is
 - unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than twelve (12) months, provided the Dependent Child was an eligible Dependent at the time coverage otherwise would terminate due to age, and
 - the Active Carpenter or Special Class Employee provides more than one-half of the Dependent Child's support for the Calendar Year and is eligible for tax-free health coverage as a "qualifying child" or "qualifying relative" under the applicable requirements of the Internal Revenue Code section 152(c) or 152(d), respectively.
 - In the event the Administrative Office determines in its complete discretion that it can satisfy tax information reporting requirements acting alone without a withholding obligation other than one on the Contributing Employer, on an administratively feasible basis, it may waive the limitation of the preceding two sentences.
 - A child whose coverage has terminated coverage under this Plan due to reaching the age limit, is not eligible to re-enroll at a later date as an adult disabled Dependent child under this Plan.
- 2) A **Qualified Medical Child Support Order (QMCSO)** beneficiary means a child who is an Eligible Individual by reason of a Qualified Medical Child Support Order or National Medical Support Notice.

b. Exclusions from Definition of Dependent

- **The following children are not eligible under the Plan:** foster child, child of a Domestic Partner, grandchild, and niece/nephew unless the employee has been awarded legal custody or guardianship of the child.
- If a Dependent may claim that status by reason of a relationship to more than one Active Carpenter or Special Class Employee, the Dependent will irrevocably elect, in accordance with procedures established by the Administrative Office, to derive Dependent status from one such person (subject to any Qualified Medical Child Support Order).
- Parents or siblings of Active Carpenters, Special Class Employees or of the Spouse of such Eligible Individuals are not Dependents under this Plan in any circumstance.
- Any Spouse that is eligible as an Active Carpenter or Special Class Employee cannot also be eligible as a Dependent unless such Spouse is also a Dependent Child under the age of 26.
- Any child who has the right to be eligible as a Dependent cannot simultaneously become eligible as an Active Carpenter or Special Class Employee.
- If a child has the right to be covered as a Dependent of more than one Active Carpenter or Special Class Employee, no duplication of benefits, or additional benefit under this Plan, will

result.

c. **Special Definition of Dependent for Life Insurance and other Non-Health Benefits**

- The definition of Dependent as outlined above applies for purposes of becoming an Eligible Individual for medical, Prescription Drug, dental and vision benefits. For other benefits if provided by the Plan, such as life insurance, the Plan is not required to, and does not extend coverage to, Dependent Children through age 26 on and after January 1, 2012. For such non-health benefits, (i) the first two bullets below will be applicable in lieu of the second bullet under “In General” above, and (ii) the third bullet will be applicable in lieu of the third bullet under “In General” above.
- An unmarried Dependent Child through the end of the month in which the child reaches age 19 and further provided the Active Carpenter or Special Class Employee provides more than one-half of the Dependent Child’s support for the Calendar Year.
- An unmarried Dependent Child who has not attained age 23 and is unmarried, supported by the employee, not employed on a full-time basis and is a full time student in an accredited institution of learning, (under that institution’s standards for full time students) and further provided the Active Carpenters of Special Class Employee provides more than one-half of the Dependent Child’s support for the Calendar Year, and further provided that loss of such student status for reasons protected by “Michelle’s Law” will not result in loss of such status in accordance with such law. For Life insurance, you must also provide for your children, a copy of your most recent federal income tax return showing that you claim the children as your Dependents.
- An unmarried Dependent Child who, on the last day of the month in which such Dependent Child attains age 19 and continuously thereafter, is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than twelve (12) months, provided the Dependent Child was an eligible Dependent at the time coverage otherwise would terminate due to age and further provided the Active Carpenter or Special Class Employee provides more than one-half of the Dependent Child’s support for the Calendar Year. Appropriate documentation must be provided to the Administrative Office within 60 days of the Dependent’s termination date and periodically as requested by the Administrative Office.

DPPO Dental Plan Option means insured PPO dental care coverage provided by an insurance company under contract to the Plan.

Drug means any commodity which can be lawfully dispensed, as provided under the Federal Food, Drug and Cosmetic Act including any amendments thereto, only upon a written or oral prescription of a Physician or Dentist licensed by law to administer it.

Durable Medical Equipment means equipment that:

- a. can withstand repeated use;
- b. is primarily and customarily used to serve a medical purpose;
- c. is generally not useful to a person in the absence of injury or sickness; and
- d. is appropriate for use in the home.

Effective Date means January 1, 2019, upon which the provisions of this SPD/Plan Document will take effect, except with respect to specific provisions herein which provide for an Effective Date of other than January 1, 2019, in which case such alternatively provided date will be the Effective Date for such provision. A provision will be applicable for claims incurred on and after the Effective Date of such provision.

Eligible Individual means an Active Carpenter, Special Class Employee, Dependent, or COBRA participant who is entitled to Plan benefits by reason of meeting the eligibility requirements summarized in Chapter 3 of this booklet. See also the definition of Spouse and Dependent in this Glossary Chapter.

Eligible Medical Expenses/Eligible Charges: Expenses for medical services or supplies, but only to the extent that the expenses meet all of the following qualification as determined by the Plan Administrator or its Delegate: are Medically Necessary, as defined in this Definitions chapter; and the charges for them are an Allowed Charge, as defined in this Definitions chapter; and coverage for the services or supplies is not excluded, as explained in the Exclusions chapter; and the Lifetime, Limited Overall, and/or Annual Maximum Plan benefits for those services or supplies have not been reached; and are for the diagnosis or treatment of an injury or illness (except where wellness/Preventive Services are payable by the Plan as noted in the Schedule of Medical Benefits in this document. An expense is incurred on the date the service or supply is received.

Eligibility Quarter means a period of three (3) consecutive calendar months beginning February 1, May 1, August 1, or November 1.

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a **prudent layperson**, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in various types of serious harm.

- In the event of a Behavioral Health Disorder, the lack of the treatment could reasonably be expected to result in immediate danger of the patient harming themselves and/or other persons, or is immediately unable to provide for or utilize food, shelter, and clothing due to a mental disorder.
- With respect to a pregnant woman who is having contractions, there is inadequate time to effect a safe transfer to another Hospital before delivery, or the transfer may pose a threat to the health or safety of the woman or the woman's unborn child.

Emergency Services means with respect to an Emergency Medical Condition (defined below), a medical screening examination **within the Emergency Department (Emergency Room or ER) of a Hospital** including ancillary services routinely available to the Emergency department to evaluate the Emergency Medical Condition, along with additional medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the Hospital to stabilize the patient.

- The term "to stabilize" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an Emergency Medical Condition, to deliver a newborn child (including the placenta).
- The term "**Emergency Medical Condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a **prudent layperson** who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to a) result in serious jeopardy to the health of the individual (or for a pregnant woman, the health of the woman or the woman's unborn child), b) serious impairment to bodily functions or c) serious dysfunction of any bodily organ or part.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

Essential Health Benefits (EHB) means the following benefits defined as Essential Health Benefits under the Affordable Care Act: ambulatory patient services; Emergency Services; hospitalization;

maternity and newborn care; mental health and Substance Use Disorder services, including Behavioral Health treatment; Prescription Drugs; rehabilitative and Habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services including oral and vision care. Pursuant to the Affordable Care Act (ACA), there are no annual or lifetime dollar limits on “Essential Health Benefits” in the Anthem Medical PPO Plan. The Board of Trustees have elected the Utah state benchmark plan to determine what are “Essential Health Benefits.”

Experimental and/or Investigational and/or Unproven. The Plan Administrator or its Delegate has the discretion and authority to determine if a service or supply is or should be classified as Experimental and/or Investigational or Unproven. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

A service or supply will be deemed to be Experimental and/or Investigational or Unproven if, in the opinion of the Plan Administrator or its Delegate, **based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for Preauthorization under the Plan’s Utilization Management program, any of the following conditions were present with respect to one or more essential provisions of the service or supply:**

1. The service or supply is described as an alternative to more conventional therapies in the protocols (the Plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the Health Care Provider that performs the service or prescribes the supply;
2. The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law;
3. In the opinion of the Plan Administrator or its Delegate, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States; and written by experts in the field; that shows that recognized medical, dental or scientific experts: classify the service or supply as Experimental and/or Investigational or unproven; or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies;
4. With respect to services or supplies regulated by the US Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current Investigational new Drug or new device application has been submitted and filed with the FDA.
5. Note that under this medical plan, Experimental, Investigational or unproven does not include **routine costs associated with a certain “approved clinical trial” related to cancer or other life-threatening illnesses.** For individuals who will participate in a clinical trial, preauthorization is recommended in order to determine if the participant is enrolled in an “approved clinical trial” and notify the Plan’s claims administrator(s) that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial. The routine costs that are covered by this Plan are discussed below:
 - a. **“Routine costs”** means services and supplies incurred by an Eligible Individual during participation in a clinical trial if such expenses would be covered for a participant or beneficiary who is not enrolled in a clinical trial. However, the Plan does not cover non-routine services and supplies, such as: (1) the Investigational items, devices, services or Drugs being studied as part of the approved clinical trial; (2) items, devices, services and Drugs that are provided solely for data collection and analysis purposes and not for direct clinical

management of the patient; or (3) items, devices, services or Drugs inconsistent with widely accepted and established standards of care for a patient’s particular diagnosis.

- b. An “**approved clinical trial**” means a phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The clinical trial or investigation must be (1) federally-funded; (2) conducted under an Investigational new Drug application reviewed by the Food and Drug Administration (FDA); or (3) a Drug trial that is exempt from Investigational new Drug application requirements. “Federally funded” clinical trials include those approved or funded by one or more of: the National Institutes of Health (NIH), the Centers for Disease Control & Prevention (CDC), the Agency for Health Care Research and Quality (AHCRO), the Centers for Medicare and Medicaid Services (CMS), a cooperative group or center of the NIH, CDC, AHCRO, CMS, the Department of Defense (DOD), the Department of Veterans Affairs (VA); a qualified non-governmental research entity identified by NIH guidelines for grants; or the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- c. A participant or beneficiary covered under a group health plan is eligible to participate in a clinical trial and receive benefits from a group health plan for routine services if: (1) the individual satisfies the eligibility requirements of the protocol of an approved clinical trial; and (2) either the individual’s referring Physician is a participating health care provider in the Plan who has determined that the individual’s participation in the approved clinical trial is medically appropriate, or the individual provides the Plan with medical and scientific information establishing that participation in the trial would be medically appropriate.
- d. The Plan may require that an Eligible Individual use a Network provider as long as the provider will accept the patient. This Plan is only required to cover out-of-network costs for routine clinical trial expenses if the clinical trial is only offered outside the patient’s state of residence.
- e. The Plan may rely on its Utilization Management Company or other medical review firm to determine, during a review process, if the clinical trial is related to cancer or a life-threatening condition, as well as to help determine if a person’s routine costs are associated with an “approved clinical trial.” During the review process, the person or their attending Physician may be asked to present medical and scientific information that establishes the appropriateness and eligibility for the clinical trial for the person’s condition. The Plan (at no cost to the patient) reserves the right to have the opinion of a medical review firm regarding the information collected during the review process.

See the Claim Filing and Claim Appeals Chapter 15 for information on the appeal process of the Plan. Additionally, external review is available for an adverse determination related to coverage of routine costs in a clinical trial. See Chapter 4 for information on preauthorization requirements.

In determining if a service or supply is or should be classified as Experimental and/or Investigational or Unproven, the Plan Administrator or its Delegate will rely only on the following specific information and resources **that are available at the time the service or supply was performed, provided or considered for Preauthorization under the Plan’s Utilization Management program:**

- 1. Medical or dental records of the covered person;
- 2. The consent document signed, or required to be signed, in order to receive the prescribed service or supply;

3. Protocols of the Health Care Provider that renders the prescribed service or prescribes or dispenses the supply;
4. Authoritative peer reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person’s diagnosis, including, but not limited to “United States Pharmacopeia Dispensing Information”; and “American Hospital Formulary Service”;
5. The published opinions of: the American Medical Association (AMA), or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Centers for Disease Control & Prevention (CDC); or the Office of Technology Assessment; clinical policy bulletins of major insurance companies in the U.S. such as Aetna, Anthem, CIGNA, or UnitedHealthcare (UHC), or MCG Care Guidelines, formerly Milliman Care Guidelines, or the National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines or, the clinical decision support resource titled “UpToDate,” or, the American Dental Association (ADA) with respect to dental services or supplies.
6. Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.
7. The latest edition of “The Medicare National Coverage Determinations Manual.”

Extended Care Facility (may also be referred to as a **Skilled Nursing Facility**) means an institution which is primarily engaged in providing inpatients with (1) skilled nursing care and related services for patients who require medical or nursing care or (2) rehabilitative services for the rehabilitation of injured, disabled or sick persons, and (3) which meets all of the following requirements:

- it is regularly engaged in providing skilled nursing care for sick and injured persons under 24-hour-a-day supervision of a Physician or a Registered Nurse,
- it has available at all times the services of a Physician who is a staff member of a Hospital,
- it has on duty 24 hours a day a Registered Nurse, licensed vocational nurse (L.V.N.) or skilled practical nurse, and it has a Registered Nurse on duty at least 8 hours per day,
- it maintains a clinical record for each patient, and
- it is not, other than incidentally, a place for rest, a place for Custodial Care, a place for the aged, a place for Drug addicts, a place for alcoholics, a hotel or a similar institution.
- it is not, other than incidentally, a place for rest, a place for Custodial Care, a place for the aged, a place for Drug addicts, a place for alcoholics, a hotel or a similar institution, and
- it complies with all licensing and other legal requirements, and is recognized as an “Extended Care Facility” by the Secretary of Health and Human Services of the United States pursuant to Title XVII of the Social Security Amendments Act of 1965, as amended.

Formulary means the list of preferred medications adopted by the Anthem Medical PPO Plan that includes Drugs that are safe, clinically effective, and economical. The Plan has adopted as its Formulary under the Anthem Medical PPO Plan’s outpatient Prescription Drug Benefit, a list of medications formulated by its pharmacy benefit manager.

Genetic Counseling means counseling services provided before Genetic Testing to educate the patient about issues related to chromosomal abnormalities or genetically transmitted characteristics and/or the possible impacts of the results of Genetic Testing; and provided after Genetic Testing to explain to the patient and their family the significance of any detected chromosomal abnormalities or genetically transmitted characteristics that indicate either the presence of or predisposition to a disease or disorder of the individual tested, or the presence of or predisposition to a disease or disorder in a fetus of a pregnant woman to allow the patient to make an informed decision.

Genetic Information means information regarding the presence or absence of chromosomal abnormalities or genetically transmitted characteristics in a person that is obtained from Genetic Testing or that may be inferred from a person's family medical history.

Genetic Testing means tests that involve the extraction of DNA from an individual's cells and analysis of that DNA to detect the presence or absence of chromosomal abnormalities or genetically transmitted characteristics that indicate the presence of a disease or disorder, the individual's predisposition to a disease or disorder, or the probability that the chromosomal abnormality or characteristic will be transmitted to that person's child, who will then either have that disease or disorder, a predisposition to develop that disease or disorder, or become a carrier of that abnormality or characteristic with the ability to transmit it to future generations.

Habilitative/Habilitation: Health care services, such as physical therapy, occupational therapy, and/or speech-language pathology, provided to individuals with developmental delays that have never acquired normal functional abilities. Examples of Habilitative services include Physician-prescribed therapy for a child who is not walking or talking at the expected age.

Health Care Operations has the meaning set forth at 45 C.F.R. § 164.501 and include, but will not be limited to, any of the following activities of the Plan to the extent that the activities are related to Covered Functions:

- a. quality assessment and improvement activities, including patient safety activities;
- b. population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;
- c. rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;
- d. underwriting (the Plan does not use or disclose PHI that is Genetic Information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
- e. conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- f. business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including Formulary development and administration, development or improvement of methods of payment or coverage policies; and
- g. business management and general administrative activities of the entity, including, but not limited to:
 1. Management activities relating to implementation of, and compliance with, the requirements of HIPAA;
 2. Customer service, including the provision of data analyses for policyholders, Plan Sponsors, or other customers;
 3. Resolution of internal grievances;
 4. Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a Covered Entity or, following completion of the sale or transfer, will become a Covered Entity; and
 5. Consistent with the applicable requirements of 45 C.F.R. § 164.514, creating de-identified health information or a limited data set and fundraising for the benefit of the Covered Entity.

Health Care Practitioner means a health care professional for whom the Plan recognizes as qualified to perform certain health care services for which Plan benefits may be provided and includes a Physician, and to the extent benefits are provided by the Plan, will also include health care professionals with the following professional designations when state licensed or certified and when acting within the scope of the Provider's license or certification:

- a. Registered nurse practitioner (CRNP),
- b. Registered nurse anesthetist (CRNA),
- c. Rehabilitation Registered Nurse (CRRN),
- d. Certified Nurse Midwife (CNM),
- e. Doctor of chiropractic (DC),
- f. Doctor of Dentistry (DDS),
- g. Doctor of medical Dentistry (DMD),
- h. Doctor of podiatric medicine (DPM),
- i. Family nurse practitioner (FNP),
- j. Licensed clinical social worker (LCSW),
- k. Licensed vocational nurse (LVN),
- l. Master of nursing , nurse practitioner (MNP),
- m. Master of nursing (MSN),
- n. Master of social work (MSW),
- o. Nurse practitioner (NP),
- p. Occupational therapist (OT),
- q. Physician assistant (PA),
- r. Physician assistant certified (PA-C),
- s. Doctor of psychology (PsyD),
- t. Physical therapist (PT),
- u. Registered Nurse (RN),
- v. Registered nurse certified (RN-C),
- w. Registered nurse clinical specialist (RNCS),
- x. State licensed Registered Nurse first assistant (RNFA),
- y. Registered nurse, nurse practitioner (RN/NP),
- z. Registered pharmacist (RPh),
- aa. State certified alcoholic counselor,
- bb. Licensed speech pathologist or licensed speech therapist,
- cc. Licensed perfusionist,
- dd. Licensed paramedic,
- ee. Licensed audiologist,
- ff. Licensed practical nurse (LPN),
- gg. Licensed alcohol and Drug counselor (LADC),
- hh. Licensed social worker (LSW),
- ii. Registered physical therapist (RPT),
- jj. Registered occupational therapist (ROT).

In addition, the Plan in its discretion may recognize a licensed provider acting within the scope of the Provider's license that provides mental health care analogous to medical care provided in an equivalent setting. Under this Plan a Health Care Practitioner is sometimes referred to as a Recognized Provider.

Health Information has the meaning set forth at 45 C.F.R. § 160.103 and include any information, whether oral or recorded in any form or medium, that:

- a. is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and

- b. relates to the past, present, or future physical or mental health or condition of an Individual; the provision of health care to an Individual; or the past, present, or future payment for the provision of health care to an Individual.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191 §§ 261-62, 264, 42 U.S.C. §§ 1320d et seq., and its implementing regulations codified at 45 C.F.R. 160.101 et seq.

HMO means a “health maintenance organization” that contracts with the Trust to provide most medical plan services for a flat fee to the Trust, and which is an insured medical care option under the Plan. The HMO generally includes a broad network of HMO providers in a geographic region, and only covers services outside the network in cases of an Emergency or when an in-network provider is not available to provide needed treatment.

Home Health Care Agency means an organization or agency that meets the requirements for participation as a “Home Health Care Agency” under Medicare.

Hospital means an institution that is a:

- legally operating as a Hospital which (1) is primarily engaged in providing, for compensation from its patients, inpatient medical and surgical facilities for diagnosis and treatment of sickness or injury or the care of pregnancy, (2) is operated under the supervision of a staff of Physicians and (3) continuously provides nursing services by Registered Nurses for 24 hours or every day; or
- State-licensed acute psychiatric Hospital as defined in subdivision (b) of Section 1250 of the California Health and Safety Code operating pursuant to licensure by the California State Department of Health Services or pursuant to a waiver of licensure by the California State Department of Mental Health, or which, in the determination of the Board or its Delegate, meets equivalent requirements of another State, which is not (1) an institution which is operated principally as a rest, nursing or convalescent home or for the care and treatment of Drug addicts or alcoholics or (2) any institution or part thereof which is primarily devoted to the care of the aged or any institution engaged in the schooling of its patients.

Hours Worked means only:

- a. those hours of work by an Active Carpenter for a Contributing Employer which are covered by a Collective Bargaining Agreement, and with respect to which contributions by such Contributing Employer to the Trust are required by such Collective Bargaining Agreement; for purposes of the preceding clause of this Article I, Section 50(a), hours of work, and, therefore, Hours Worked, shall not include hours of work in excess of a periodic cap specified in such Collective Bargaining Agreement (such as, for example, 35 hours in a calendar week) unless the Collective Bargaining Agreement is an In Lieu Agreement subject to the temporary moratorium or waiver rules of Article I, Section 51(b) where the Board’s approval specifically identifies the hours cap and indicates the Board’s intent that hours of work in excess of the cap are to be counted as Hours Worked under this Article I, Section 50(a) during the period of the temporary moratorium or waiver.
- b. hours for which no contribution is required, due to a temporary moratorium or waiver specified in an In Lieu Agreement which contemplates that such hours will be Hours Worked hereunder and where the Board’s approval of such In Lieu Agreement encompasses crediting of such hours as Hours Worked;
- c. qualified family or medical leave hours credited in accordance with Article II, Section 2(a); and
- d. daytime JATC training hours completed by Active Carpenter apprentices in accordance with Article II, Section 1(b)(5).

In Lieu Agreement means an agreement:

- a. between the Union and a Contributing Employer which covers work performed by an Active Carpenter and contemplates that such work will constitute Hours Worked on the conditions regarding contributions and other obligations of the Contributing Employer to the Trust which are described in such agreement, which conditions do not impose upon the Contributing Employer obligations with respect to the Trust which are substantially similar to those imposed upon employers who are bound to the Master Labor Agreement; and
- b. which is approved by the Board or the Health Care Benefits Committee.

Individually Identifiable Health Information has the meaning set forth at 45 C.F.R. § 160.103 and will include information that is a subset of Health Information, including demographic information collected from an Individual, and:

- a. is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
- b. relates to the past, present, or future physical or mental health or condition of an Individual; the provision of health care to an Individual; or the past, present, or future payment for the provision of health care to an Individual; and
- c. that identifies the Individual; or
- d. with respect to which there is a reasonable basis to believe the information can be used to identify the Individual.

JATC means Joint Apprenticeship Training Committee.

Maintenance Rehabilitation means therapy in which a patient actively participates, that is provided after a patient has met the functional goals of Active Rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonably be prescribed to maintain, support, and/or preserve the patient's functional level.

Master Labor Agreement means the Master Labor Agreement between the Union and the United General Contractors, Inc., and any extension, modification, renewal, substitute or successor thereto.

Medically Necessary/Medical Necessity means, when applied to a service or supply:

- a medical service or supply which is reasonably necessary for the care or treatment of bodily injury or sickness,
- a dental service or supply which is reasonably necessary for dental care, and
- a mental health/Substance Use Disorder service or supply which is reasonably necessary to provide treatment for mental health/Substance Use Disorders.

The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, in and of itself, make that service or supply reasonably necessary for purposes of the preceding sentence. The determination of Medically Necessary will be made by the Board or its Delegate in the sole and absolute discretion of the Board or the Delegate.

Notwithstanding any inconsistency with this definition, where the Delegate is Anthem Blue Cross pursuant to the Administrative Services Agreement for the Plan entered into by the Trust on or after January 1, 2012, and the claim entails a determination of Medically Necessary by such Delegate, the claim will be adjudicated by such Delegate consistent with its definition, standards and policies respecting Medical Necessity.

Medicare means the program established under Title XVII of the Social Security Act (Federal Health Insurance for the Aged) as it is presently constituted or may hereafter be amended.

Nondurable Supplies means goods or supplies that **cannot withstand** repeated use and/or that are considered **disposable** and limited to either use by a single person or one-time use, including, but not limited to, bandages, syringes (except to administer covered Drugs), diapers, soap or cleansing solutions, etc. Only those nondurable supplies identified in the Schedule of Medical Benefits are covered by this Plan. All others are not.

Orthotic (Appliance or Device): A type of Corrective Appliance or device, either customized or available “over-the-counter,” designed to support a weakened body part, including, but not limited to, crutches, specially designed corsets, leg braces, extremity splints, and walkers. This definition does **not** include Dental Orthotics.

Out-of-Pocket Limit is the most a Plan participant pays in cost-sharing (Deductibles, Copayment and Coinsurance) during a one-year period (the Calendar Year) before the Plan starts to pay 100% for covered Essential Health Benefits received from in-network providers. There is no Out-of-Pocket Limit on the use of Out-of-Network providers under the Anthem Medical PPO Plan in this document, except that Emergency Services performed in an Out-of-Network Emergency Room will accumulate to meet the In-network Out-of-Pocket Limit. Out-of-Pocket Limit is explained more fully in Chapters 4 and 5.

Partial Confinement Treatment Program (Partial Day Care/Partial Hospitalization) is a planned program of mental health/Substance Use Disorder treatment which is subject to favorable modification given by a Psychiatric (Behavioral Health) Treatment Facility on a day care basis (the program must be available for at least 6 hours during the day and at least 5 days a week) or the Partial Confinement Treatment Program must meet all of the following requirements:

- it involves any generally accepted form of evaluation and treatment of a condition diagnosed as mental illness which does not require full-time confinement, and
- it is supervised by a Physician who either specializes in psychiatric medicine or has, by reason of training or experience, a specialized competency in the field of psychiatric medicine sufficient to render the necessary evaluation and treatment of mental illness, and
- has a supervising Physician reviews the program and evaluates its effectiveness at least once a week.

Participating Pharmacy means a pharmacy that is under contract with the Pharmacy Benefit Manager (PBM) to dispense Prescription Drugs to Eligible Individuals. See the Quick Reference Chart at the front of this document for the contact information for the outpatient Prescription Drug Program (also known as the Pharmacy Benefit Manager).

Passive Rehabilitation refers to therapy in which a patient does **not** actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive Rehabilitation may be covered by the Plan during a course of Hospitalization for acute care. Techniques for Passive Rehabilitation are commonly taught to the family/caregivers to employ on an outpatient basis with the patient when and until such time as the patient is able to achieve Active Rehabilitation.

Payment has the meaning set forth at 45 C.F.R. § 164.501 and include activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits or to obtain or provide reimbursement for the provision of health care. Payment activities will include, but not be limited to, the following:

- a. determination of eligibility, coverage, and cost sharing amounts (e.g., cost of a benefit, Plan maximums, and Copayments as determined for an individual’s claim);
- b. coordination of benefits;

- c. adjudication of health benefit claims (including appeals and other Payment disputes);
- d. subrogation of health benefit claims;
- e. risk adjusting amounts due based on enrollee health status and demographic characteristics;
- f. billing, claims management, collection activities, including auditing Payments, investigating and resolving Payment disputes and responding to participant inquiries about Payments, and related health care data processing;
- g. obtaining Payment under a contract for reinsurance (including stop-loss and excess of loss insurance) and related health care data processing;
- h. Medical Necessity reviews, or review of appropriateness of care or justification of charges;
- i. utilization review, including precertification/preauthorization, concurrent review, case management, and retrospective review of services; and
- j. disclosure to consumer reporting agencies of any of the following related to collection of premiums or reimbursement: name and address, date of birth, SSN, Payment history, account number, and name and address of the provider and/or health Plan).

PBM means the pharmacy benefits manager that is under contract with the Trust.

Physician means a person acting within the scope of the Physician’s license and holding a degree of Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatric Medicine (D.P.M.) or Doctor of Dental Medicine (D.M.D.), who is legally entitled to practice medicine under the laws of the state or jurisdiction where the services are rendered. See also the definition of Health Care Practitioner in this Glossary Chapter.

Plan means the Southwest Carpenters Health and Welfare Plan for Active Carpenters Restated January 1, 2019, as set forth in the SPD/Plan Document, as duly amended by resolution of the Board or its authorized Delegate, the Health Care Benefits Committee.

Plan Administration Functions has the meaning set forth at 45 C.F.R. § 164.504 and include administration functions performed by the Administrative Office as a Delegate of the Board on behalf of the Plan and excludes functions performed by the Board in connection with any other benefit or benefit plan of the Trust.

Plan Administrator refers to the Board of Trustees of the Southwest Carpenters Health and Welfare Plan.

Plan Sponsor has the meaning set forth in ERISA Section 3(16)(B) and as used herein will refer to the Board of Trustees of the Southwest Carpenters Health and Welfare Plan.

Plan Year means the Plan’s fiscal year for audit, financial control, administrative and reporting and disclosure obligations under ERISA, and will be the Calendar Year.

PPO means the preferred provider organization(s) under contract with the Trust to provide favorable prices for services from network providers under the Anthem Medical PPO Plan.

Preventive Care Services/Preventive Services means:

- services with an “A” or “B” rating from the U.S. Preventive Services Task Force (USPSTF),
- immunizations recommended by the Centers for Disease Control and Prevention’s Advisory Committee on Immunization Practices (ACIP),
- and with respect to infants, children, and adolescents, and women’s additional Preventive Care and screenings provided for in guidelines supported by the Health Resources and Services Administration (HRSA) including Bright Futures.

- These websites (periodically updated) provide more information on Preventive Care services: <https://www.healthcare.gov/what-are-my-preventive-care-benefits/> with more details at
 - <http://www.cdc.gov/vaccines/schedules/hcp/index.html>,
 - <http://www.hrsa.gov/womensguidelines/>,
 - <https://mchb.hrsa.gov/maternal-child-health-topics/child-health/bright-futures.html>, and
 - <https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/>.

Preventive Care Services include certain prenatal care for female Eligible Individuals, breastfeeding (support, supplies, rental of equipment, and lactation counseling while breastfeeding), and all FDA-approved contraceptive methods for women.

An office visit to a Physician will be considered a Preventive Care Service if the primary purpose for the visit is the delivery of a Preventive Care Service and no separate charge is made for the Preventive Care Service provided during the visit.

Prosthetic Appliance (or Device): A type of Corrective Appliance or device designed to replace all or part of a missing body part, including, but not limited to, artificial limbs and eyes, or a heart pacemaker.

Protected Health Information (PHI) has the meaning set forth at 45 C.F.R. § 160.103 and includes Individually Identifiable Health Information that is transmitted, received, or maintained in any form or medium by the Covered Entity, but excluding Individually Identifiable Health Information in:

- a. education records covered by the Family Educational Rights and Privacy Act (FERPA), as amended, 20 U.S.C. 1232g;
- b. records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and
- c. Plan enrollment records such as eligibility records held by a Covered Entity in its role as employer.

Psychiatric Treatment Facility as it applies to the treatment of a nervous or mental or Behavioral Health condition, means a Hospital or an institution including a Residential Treatment Facility, or a distinct part of a Hospital, which meets all of the following requirements:

- a. it is primarily engaged in providing, for compensation from its patients, a program for diagnosis, evaluation and treatment of mental or nervous disorders. It is not primarily a school or a Custodial, recreational or training institution;
- b. it provides, or has an agreement with a Hospital in the area to provide, medical services for the treatment of any physical disease or injury manifested during the treatment period;
- c. it is under the continuous supervision of a Physician psychiatrist who has the overall responsibility for coordinating patient care and who is at the facility on a regularly scheduled basis;
- d. it is staffed by Physician psychiatrists who are directly involved in the treatment program, at least one of whom is present at all times during the treatment program, and continuously provides the service of psychiatric Registered Nurses and licensed psychiatric social workers;
- e. it prepares and maintains a written individual treatment plan for each patient based on a diagnostic assessment of the patient's medical, psychological and social needs with documentation that the Plan is under the supervision of a Physician psychiatrist;
- f. it meets any applicable licensing standards established by the jurisdiction in which it is located; and
- g. it continuously provides skilled nursing services under the direction of a full time Registered Nurse, with licensed nursing personnel on duty at all times.

Reciprocal Agreement means an agreement between two or more multiemployer funds or plans to allow an employee's covered employment in another plan's jurisdiction to be credited toward a benefit in the employee's Home Plan.

Recognized Provider see the definition of Health Care Practitioner in this Glossary Chapter.

Registered Nurse means a person acting within the scope of the Registered Nurse's license and holding a degree/license of a Registered Nurse (RN), Registered Nurse Certified (RN-C), Registered Nurse Clinical Specialist (RNCS), State Licensed Registered Nurse First Assistant (RNFA), Registered Nurse, Nurse Practitioner (RN/NP), Registered Nurse Practitioner (CRNP), Rehabilitation Registered Nurse (CRRN), or Certified Registered Nurse Anesthetist (CRNA).

Rehabilitation Services/Rehabilitation Therapy: Physical, occupational, or speech therapy that is prescribed by a Physician when the bodily function has been restricted or diminished as a result of illness, injury or Surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness or Surgery, and that is performed by a licensed therapist acting within the scope of their license.

Rehabilitation does not have the same meaning as Habilitation. Rehabilitation focuses on restoring/regaining functions that have been lost due to injury or illness, while Habilitation focuses on therapy to help an individual attain certain functions that have never have acquired, such as speech therapy to assist a child in learning to talk. See also the definition of Habilitation.

See the Schedule of Medical Benefits in Chapter 5 and the Exclusions in Chapter 6 to determine the extent to which Rehabilitation Therapies are covered. See also the definition of Active Rehabilitation, Maintenance Rehabilitation and Passive Rehabilitation in this Glossary Chapter.

Rehabilitation Facility Treatment means inpatient Rehabilitation Services in a licensed acute care Hospital rehabilitation unit or Skilled Nursing Facility for short term, active, progressive Rehabilitation Services that cannot be provided in an outpatient or home setting. Treatment may include cardiac, occupational, physical, pulmonary or speech therapy that is prescribed by a Physician when the bodily function has been restricted or reduced as a result of Illness, Injury or Surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the Injury, Illness or Surgery.

Residential Treatment Program/Facility/Care: is an intermediate non-Hospital inpatient setting with 24-hour care that operates 7 days a week, for individuals with Behavioral Health disorders including mental (psychiatric) disorders or Substance Use/abuse (alcohol/Drug) disorders that are unable to be safely and effectively managed in outpatient care. To be considered payable by this Plan, a facility must be licensed as a Residential Treatment Facility (licensure requirements for this residential level of care may vary by state). In addition to licensure, the Residential Treatment Facility must also have evidence the patient admission was ordered by a Physician, comprehensive written patient assessment upon admission to include eligibility and suitability for admission, onsite licensed Behavioral Health providers providing at least 20 hours/week of individual and group counseling, and 24/7 access to necessary medical and Prescription Drug services, along with discharge criteria with a written discharge summary.

Rules and Regulations means:

- a. the Plan's Summary Plan Description/Plan Document and amendments to such document(s);
- b. resolutions of the Board allocating or delegating fiduciary or administrative responsibilities respecting the Plan or Trust;
- c. written procedures respecting the Plan adopted by the Board, or a committee thereof which is a Delegate, or promulgated by the Administrative Office; including the Plan's HIPAA Procedures

as established by and adopted in writing by the Administrative Office (most recently restated in May, 2012) as the HIPAA compliance Delegate of the Board for the Plan.

- d. written enrollment forms and written claims policies, procedures and forms regarding the Plan, as promulgated by the Administrative Office regarding the Plan, a provider described in the Plan or a Delegate who is a contracted claims processor (including Anthem Blue Cross pursuant to its Administrative Services Agreement with the Trust which is effective on or after the Effective Date). A decision upon a claim by the Administrative Office or other Delegate, or upon an appeal of a claim denied by a Delegate or the Appeals Committee, will apply only to the facts of such case and will not constitute a part of the Rules and Regulations.

Security Incident has the meaning for that term set forth at 45 C.F.R. §§ 164.304 and include the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

Skilled Nursing Facility (SNF): See the definition of Extended Care Facility.

Special Class Employee means an employee of an employer that is related to the United Brotherhood of Carpenters (UBC) or the Plan that has adopted the Plan for the benefit of such employee under special rules within the Plan allowing coverage of employees that are not members of a UBC bargaining unit. See “Special Class Employees” in Chapter 3 for further information on the different Plan eligibility rules that apply to Special Class Employees.

Spouse means a person who is **legally married** to the employee under State law. The Plan may require **proof** of the legal marital relationship. The following are not defined as a Spouse under this Plan and are therefore **not eligible** for coverage:

- a. a legally separated Spouse, even if an employee is required by a divorce decree, court order, or other legal action to continue to provide coverage for the ex-Spouse,
- b. a Domestic Partner, (Note that a Domestic Partner may be covered as a Dependent on a Life Insurance policy as explained in the Eligibility Chapter of this document.)
- c. a civil union,
- d. a divorced former Spouse (an ex-Spouse) of an employee even if an employee is required by a divorce decree, court order, or other legal action to continue to provide coverage for the ex-Spouse,
- e. a common law marriage (unless such common law marriage was recognized as valid by the laws of the state of residence), or
- f. a Spouse of a Dependent Child.

Substance Abuse or Substance Use Disorder means alcoholism, Drug addiction or Drug abuse

Substance Abuse Treatment Center means a chemical dependency recovery Hospital licensed by the state where services are rendered. This term will also include a center for the treatment of alcoholism, Drug addiction or Drug abuse which is licensed by the proper governmental authority to provide detoxification, counseling and rehabilitative services. Services provided by a Treatment Center must be performed by a Physician, licensed psychologist, licensed clinical social worker or State-certified alcoholic counselor.

Superintendent means a person who was once an Active Carpenter (interpreted by applying such term to periods prior to the Effective Date) who is employed by a Contributing Employer as a carpenter craft Superintendent or assistant carpenter craft Superintendent and who is engaged full-time on behalf of such Contributing Employer in supervision of Active Carpenters and their foremen.

Surgery: Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the Plan Administrator or its Delegate will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purpose of determining Plan benefits. When the procedures will be considered to be separate procedures, the following percentages of the Allowed Charge will be allowed as the Plan's benefit:

1. Allowances for multiple surgeries through the same incision or operational field:

Primary procedure	100% of the Allowed Charge
Secondary and additional procedures	50% of the Allowed Charge per procedure

2. Allowances for multiple surgeries through separate incisions or operative fields performed at the same operative session:

First site primary procedure	100% of the Allowed Charge
First site secondary and additional procedures	50% of the Allowed Charge per procedure
Second site primary and additional procedures	50% of the Allowed Charge per procedure

Temporomandibular Joint (TMJ), Temporomandibular Joint Disorder (TMD), Temporomandibular Joint (TMJ) Dysfunction or Syndrome means the Temporomandibular (or craniomandibular) Joint (TMJ) connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ/TMD dysfunction or syndrome refers to a variety of symptoms where the cause is not generally clearly established, including, but not limited to, masticatory muscle disorders producing severe aching pain in and about the Temporomandibular Joint (sometimes made worse by chewing or talking), myofascial pain (pain in the muscles of the face), headaches, earaches, limitation of the joint, clicking sounds during chewing, tinnitus (ringing, roaring or hissing in one or both ears) and/or hearing impairment. These symptoms may be associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly), ill-fitting dentures, or internal derangement of the Temporomandibular Joint.

Totally Disabled or **Total Disability** means, effective for disability requests on or after April 1, 2018, the opinion of a) an independent review organization, or b) the Social Security Administration will be considered acceptable proof of Total Disability when first applying for Long Term Disability Benefits under the Plan.

Total Disability means with respect to an Eligible Individual for purposes of long term disability benefits provided under the Plan, that the individual is:

- a. unable to engage in any substantial gainful activity because of any medically determinable physical or mental impairment that is expected to result in your death or to continue for at least 12 months, and
- b. such bodily injury or disease is not due to:
 - Your commission of or attempt to commit a felony,
 - Your engagement in any felonious activity or occupation,
 - The self-infliction of any injury, or
 - Habitual drunkenness or the use of narcotics (unless administered pursuant to the orders of a licensed Physician).

The Board may waive the application of the above provisions if good cause is established that is satisfactory to the Board. For this purpose, the written opinion by an independent review organization that is accredited by the Utilization Review Accreditation Commission (URAC) or any award of disability benefits from the Social Security Administration will be acceptable proof of Total Disability under the Plan. See also Chapter 10 for more information on Long Term Disability benefits.

Treatment has the meaning for that term set forth at 45 C.F.R. § 164.501 and include the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

Trust means the Southwest Carpenters Health and Welfare Trust.

Trust Agreement means the Amended and Restated Trust Agreement establishing the Southwest Carpenters Health and Welfare Trust Reprinted August 1, 2004, and any modification, amendment, extension or renewal thereof.

Uniformed Services means the United States Armed Services (including the Coast Guard), 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 means the Southwest Regional Council of the United Brotherhood of Carpenters and Joiners of America and any local Union affiliate thereof.

Vision Plan means an insured vision plan provided by an insurance company under contract to the Plan.

WHCRA means the Women's Health and Cancer Rights Act of 1998.

Work Quarter means a period of three (3) consecutive calendar months beginning January 1, April 1, July 1, or October 1.



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