

**Southwest Carpenters
Health and Welfare Trust
Summary Plan Description**

Describing

Health Care Benefits

Life Insurance

Accidental Death and Dismemberment Insurance

for

Eligible Active Carpenters

and their

Eligible Dependents

SOUTHWEST CARPENTERS HEALTH AND WELFARE TRUST

BOARD OF TRUSTEES

Employee Trustees

Tom Benson
James Bernsen
Floyd Clay
Gordon Hubel
Douglas McCarron
Mike McCarron
Armando Vegara
Marc Furman

Employer Trustees

Curtis Conyers, Jr.
Kim Fromer
Richard Harris
Gary Jaacks
Ralph Larison
Bert Lewitt
Ronald N. Tutor
Perry Eiman

BENEFITS CONSULTANT

The Segal Company

TRUST ADMINISTRATOR AND ADMINISTRATIVE OFFICE

Carpenters Southwest Administrative Corporation

533 South Fremont Avenue

Los Angeles, CA 90071-1706

(213) 386-8590

(800) 293-1370

CARPENTERS SOUTHWEST ADMINISTRATIVE CORPORATION

CONTACTS

ADMINISTRATIVE OFFICE

- | | |
|--|--|
| <ul style="list-style-type: none"> • Questions about eligibility or general information | <p>In California (213) 386-8590 Toll free (800) 293-1370 In Nevada, (702) 851-4510 Toll Free (800) 501-0210 In Arizona, (602) 352-6805 In Utah (801) 282-6528</p> |
| <ul style="list-style-type: none"> • Questions about benefits or claims • Requests for claim forms • Requests for pre-authorizations under the Fee-for-Service health care options (urgent care does not require pre-authorization) | <p>(213) 385-0551 or (800) 252-9255</p> <p>In Nevada, (702) 851-4510 or (800) 501-0210</p> |

PPO (Fee-for-Service Medical Option)

- | | |
|---|--|
| • Blue Cross - Questions about preferred providers in California | www.bluecrossca.com |
| • CCN – Questions about preferred providers in Arizona | www.ccnusa.com |
| • Beech Street – Questions about preferred providers in all other areas | www.beechstreet.com |

HMOs

- | | |
|---|--|
| • Kaiser (California only) | (800) 464-4000 or www.kaiserpermanente.org |
| • PacifiCare of California | (800) 624-8822 or www.pacificare.com |
| • PacifiCare of Arizona | (800) 347-8600 or www.pacificare.com |
| • Health Plan of Nevada (HPN) | (800) 777-1840 or www.healthplanofnevada.com |
| • Hometown Health | (800) 336-0123 or www.hometownhealth.com |
| • Intermountain Health Care Health Plan (IHC) | (800) 538-5038 or www.ihc.com |

DMO DENTAL PLANS

| | |
|--|----------------|
| • Pacific Union Dental – California | (800) 999-3367 |
| • Nevada Pacific Dental – Nevada | (800) 926-0925 |
| • Total Dental Administrators – Arizona and Utah | (877) 725-8758 |
| • Golden West Dental - California | (800) 995-4124 |
| • Employers Dental Services (EDS) - Arizona | (800) 722-9772 |

SPECTERA VISION CARE PLAN

Customer Service (800) 638-3120

Provider Locator (800) 839-3242

SOUTHWEST CARPENTERS HEALTH AND WELFARE PLAN AND TRUST

California:

Full Benefits Administrative Office (Headquarters)
533 South Fremont Avenue
Los Angeles, CA 90071-1706
(213) 386-8590
(800) 293-1370

Arizona:

Satellite Office
4547 W. Mc Dowell Rd.
Phoenix, AZ 85035-4121
(602) 352-6805

Utah:

Satellite Office
8149 S. Welby Park Dr.
West Jordan, UT 84088
(801) 282-6528

Nevada:

Full Benefits Administrative Office
980 Kelly Johnson Drive, Suite 180
Las Vegas, NV 89119
(702) 851-4510
(800) 501-0210

Dear 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 the United Brotherhood of Carpenters (“UBC”) and Employers signatory with UBC affiliates. The Trust sponsors the Southwest Carpenters Health and Welfare Plan for Active Carpenters Restated January 1, 2005 (the “Plan”) to provide benefits to eligible UBC active Carpenters and their eligible beneficiaries in Southern California, Nevada, Arizona and Utah.

This booklet describes the Plan eligibility rules and benefits for active Carpenters in UBC bargaining units and their families as of January 1, 2006. It also describes the Plan eligibility rules and benefits for certain UBC-related Special Class Employees, whose employers have adopted the Plan, but who are not members of UBC bargaining units.

This booklet contains descriptions of all the medical and other benefits provided directly by the Health and Welfare Trust under the Plan. Medical benefits provided under the Plan through an HMO and dental benefits provided through a DMO are summarized in an insert to this booklet—and are further detailed in separate booklets issued by those HMO and DMO managed care organizations.

To maximize the benefit of the Plan to you, we urge you to familiarize yourself with this booklet before the need for care arises. Chapter 1 describes when you are eligible for the Plan.

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

If you have any questions, please contact the Administrative Office, where the staff will be happy to assist you.

Sincerely,

BOARD OF TRUSTEES

SOUTHWEST CARPENTERS HEALTH AND WELFARE PLAN AND TRUST

Authorized Sources of Information

The only sources of authorized information about the Plan are this booklet, and HMO or other managed care provider booklets, subsequent booklet inserts (if any); the Trust Agreement; the Southwest Carpenters Health and Welfare Plan for Active Carpenters Restated January 1, 2005 (the “Plan Document”); the service or insurance agreements between the Trust and HMOs, DMOs and other managed care, health and welfare benefit coverage providers, as in effect at applicable times; written statements issued by the Administrative Office on behalf of the Plan on Carpenters Southwest Administrative Corporation letterhead; and the written statements of duly authorized representatives of HMOs, DMOs 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 individuals other than those described above 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 reliable information about the Plan.

A copy of the Trust Agreement and the Plan Document may be reviewed at the Administrative Office at the address above during normal business hours or your Local Union’s Office during normal business hours. You may obtain a copy of the Trust Agreement and/or Plan Document for a reasonable copying charge by writing to the Administrative Office.

CONTENTS

| | |
|---|----|
| Overview of Plan | 7 |
| Chapter 1 – Participating in the Plan | |
| Who is Eligible | 15 |
| Enrollment | 18 |
| Coverage During a Family or Medical Leave | 21 |
| When Eligibility Terminates | 21 |
| COBRA Continuation Coverage | 23 |
| Certificate of Creditable Coverage | 29 |
| Chapter 2 – Fee-For-Service Medical Option Summary | |
| How does the Fee-For-Service Medical Option Work? | 30 |
| What is the Deductible? | 32 |
| What is the Stop Loss Limit? | 33 |
| What is the Lifetime Maximum Benefit? | 33 |
| Pre-Authorization | 34 |
| Special Provisions Regarding Women’s Health Care | 35 |
| What is Covered? | 35 |
| What is Not Covered? | 45 |
| How to File a Claim for Benefits under the Fee-For-Service Medical Option | 46 |
| Chapter 3 – Fee-For-Service Prescription Drug Benefit Summary | |
| What are the Benefits? | 49 |
| Prescription Quantity | 50 |
| What is Covered (including Pre-Authorization Rules)? | 50 |
| What is Not Covered? | 51 |
| How to Fill Prescriptions using the Walk-In Service | 52 |
| How to Fill Prescriptions using the Mail Order Service | 52 |
| How to File a Claim for Fee-For-Service Prescription Drug Benefits | 53 |
| Chapter 4 – Vision Care Coverage Summary | |
| What are the Benefits? | 55 |
| When are Benefits Available? | 56 |
| How to Use the Program | 56 |
| What is Not Covered? | 56 |
| How to File a Claim under the Vision Care Coverage | 56 |
| Chapter 5 – Fee-For-Service Dental Option Summary | |
| What are the Benefits? | 58 |
| What is Covered? | 59 |
| What is Not Covered? | 60 |
| How to File a Claim for Benefits under the Fee-For-Service Dental Option | 60 |
| Schedule of Dental Allowances | 62 |

Chapter 6 – Employee Weekly Disability Benefits Summary

What are the Benefits?79
Limitations79
Exclusions79
Termination of Benefits80
How to File a Claim for Employee Weekly Disability Benefits80

Chapter 7 – Employee Life Insurance Summary

What are the Benefits?81
Your Beneficiary81
How to Continue your Life Insurance if you Lose Eligibility81
How to File a Claim for Employee Life Insurance82

Chapter 8 – Dependent Life Insurance Summary

What are the Benefits?83
Beneficiary83
How your Spouse may Continue Life Insurance if you Lose Eligibility83
How to File a Claim for Dependent Life Insurance84

Chapter 9 – Employee Accidental Death and Dismemberment Benefits Summary

What are the Benefits?85
Your Beneficiary86
What is Not Covered?86
How to File a Claim for Employee Accidental Death and Dismemberment Benefits86

Chapter 10 – Other Important Plan Information

Medicare and Plan Benefits87
Coordination of Benefits and Repayment Obligation87
Privacy of Health Information90
Claims Review Procedures90
Factors that could Affect your Receipt of Benefits97
General Limitations and Exclusions Summary98
Your Rights under ERISA100
General Plan Information102
Plan Facts103
Glossary of Terms used in this Booklet108

OVERVIEW OF PLAN

Below is an overview of:

- Eligibility for the Plan
- Benefit Options under the Plan
- Schedule of Benefits under the Plan's Fee-For-Service Medical Option
- How to File Claims

For a more complete description of eligibility requirements and Plan benefits, please refer to the following Chapters of this booklet (these are named in the preceding Table of Contents). If you are enrolled in an HMO and/or DMO, please refer to the benefit booklet(s) issued by those HMOs/DMOs for your medical and dental benefits.

NOTE: Capitalized terms used in this booklet have a very precise meaning (for example, “Medically Necessary”, “Emergency” or “Extended Care Facility.”) To be sure you understand the meaning of capitalized terms, please refer to the Glossary which starts on page 108 of the booklet. Example: The second definition in the Glossary explains “Allowable Charges.” These are often less than a doctor or other provider may ordinarily charge, and the Plan often pays only a percentage of “Allowable Charges.”

| OVERVIEW OF ELIGIBILITY | |
|-------------------------------------|---|
| Type of Participant | Eligibility Requirement |
| Active Carpenter | Submit your properly completed enrollment forms when due, and have 300 hours worked and reported (or drawn from your reserve bank) in the calendar eligibility 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 coverage 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. |
| Non Bargaining Unit Employee | Submit your properly completed enrollment forms when due, and be a member of a group employed by a UBC 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; 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 30 days following the date you acquired the dependent in order to be eligible for Plan benefits. |

OVERVIEW OF BENEFIT OPTIONS

| Benefit Option | Description |
|--------------------------|--|
| Medical | <p>You choose one of these applicable options:</p> <p><i>In California -</i></p> <ul style="list-style-type: none"> • Fee-for-Service Medical Plan provided directly by the Trust (this option is available only after you have been eligible for at least 12 months and enrolled in an HMO Plan unless you live outside the HMO service areas) • Kaiser HMO • PacifiCare HMO <p><i>In Arizona –</i></p> <ul style="list-style-type: none"> • Fee-for-Service Medical Plan provided directly by the Trust (this option is available only after you have been eligible for at least 12 months and enrolled in an HMO Plan unless you live outside the HMO service areas) • PacifiCare HMO <p><i>In Nevada –</i></p> <ul style="list-style-type: none"> • Fee-for-Service Medical Plan provided directly by the Trust (this option is available only after you have been eligible for at least 12 months and enrolled in an HMO Plan unless you live outside the HMO service areas) • Hometown Health HMO (Northern Nevada Only) • Health Plan of Nevada (HPN) HMO <p><i>In Utah –</i></p> <ul style="list-style-type: none"> • Fee-for-Service Medical Plan provided directly by the Trust (this option is available only after you have been eligible for at least 12 months and enrolled in an HMO Plan unless you live outside the HMO service areas) • IHC Health Plan HMO <p><i>In all other areas -</i></p> <ul style="list-style-type: none"> • Fee-for-Service Medical Plan provided directly by the Trust |
| Prescription drug | <p>Walk-in pharmacy and mail service provided for participants in the Fee-for-Service Medical Plan</p> <p><i>If you're in an HMO, you'll have your prescription drug benefits provided through the HMO instead.</i></p> |
| Vision care | <p>Vision care benefits provided by Spectera for all participants except those enrolled in Kaiser HMO</p> <p><i>If you're in the Kaiser HMO Plan, you'll have your vision care benefits provided through Kaiser instead.</i></p> |
| Dental | <p>Choice among the following options:</p> <ul style="list-style-type: none"> • Fee-for-Service Dental Plan provided directly by the Trust (this option is available only after you have been eligible for at least 12 months and enrolled in a DMO Plan unless you live outside the DMO service areas) • Pacific Union Dental DMO in California • Golden West DMO in California • Employers Dental Services (EDS DMO) in Arizona • Total Dental Administrators (TDA DMO) in Arizona and Utah • Nevada Pacific Dental (NPD DMO) in Nevada |

| Benefit Option | Description |
|--|--|
| Weekly disability benefit | <i>Only for UBC employees and certain non-bargaining employees not covered by any State Disability Insurance (SDI) or Workers Compensation benefit</i> <ul style="list-style-type: none"> • A benefit of up to \$150 per week (minus FICA deductions) for a maximum of 26 weeks |
| Life insurance on life of: | <ul style="list-style-type: none"> • Employees: \$10,000 coverage • Spouses: \$1,500 coverage • Children: \$1,500 coverage each |
| Accidental death and dismemberment insurance (employees only) | Up to \$10,000 coverage, depending on the loss |

SCHEDULE OF HEALTH CARE BENEFITS UNDER THE FEE-FOR-SERVICE MEDICAL OPTION

Please note that some of the Fee-For-Service benefits require pre-authorization from the Trust as a condition for payment of benefits. Refer to “Pre-Authorization” in Chapter 2 and Chapter 3 for details.

| Hospital/Medical Benefits for Those Enrolled in the Fee-for-Service Medical Option | | |
|---|---|---|
| PLAN FEATURES | | |
| Calendar year deductible | When services/supplies are provided by PPO Providers or non-PPO Providers: \$150 per person, \$450 maximum per family <i>Deductible is not applied to routine physical exams and second surgical opinions (see below for expense cap for these services)</i> | |
| Annual stop loss limit | \$20,000 of Allowable Charges <i>These limits do not apply to reduce your share of charges for Psychiatric Care, Substance Abuse treatment, speech therapy, non-PPO inpatient and outpatient Hospital charges or non-PPO Ambulatory Centers</i> | |
| Maximum lifetime benefit | \$1 million per person, not to exceed \$7,500 for Custodial Care from a hospice program and \$5,000 for treatment of Substance Abuse | |
| COVERED SERVICES AND SUPPLIES | COVERAGE AMOUNT | |
| | PPO PROVIDER | NON-PPO PROVIDER |
| Hospital | | |
| • Inpatient | 90% of Allowable Charges | 60% of Allowable Charges |
| • Outpatient | 90% of Allowable Charges after a separate \$50 member co-payment for each emergency room visit | 60% of Allowable Charges (90% of Allowable Charges after a separate \$50 member co-payment for Emergency treatment rendered in the emergency room of the Hospital; see Chapter 10 for the Plan’s definition of Emergency <i>Allowable Charges for non-PPO outpatient care are limited to \$5,000 per operative session for surgery-related services and supplies and \$3,500 per visit for other services (pre-admission testing, emergency room care and other Medically Necessary care)</i> |

| COVERED SERVICES AND SUPPLIES | COVERAGE AMOUNT | |
|--|---|---|
| | PPO PROVIDER | NON-PPO PROVIDER |
| Rehabilitation Facility | | |
| <ul style="list-style-type: none"> Inpatient (for severe conditions only – preauthorization recommended to possibly save you money) | 90% of Allowable Charges <i>Rehabilitation Facility Benefits are payable for a maximum of 30 days per calendar year</i> | 60% of Allowable Charges |
| <ul style="list-style-type: none"> Outpatient | Refer to the Plan’s Outpatient Physical Therapy and Speech Therapy Benefits on the next page | Refer to the Plan’s Outpatient Physical Therapy and Speech Therapy Benefits on the next page |
| Ambulatory Center (see Glossary for definition – listed benefits are only for facilities that are accredited or licensed and meet the Plan’s definition of Ambulatory Center) | 90% of Allowable Charges for surgery-related services and supplies | 60% of Allowable Charges for surgery-related services and supplies <i>Allowable Charges for non-PPO surgery-related services and supplies are limited to \$5,000 per operative session</i> |
| Extended Care Facility | Room and board: 100% of Allowable Charges for first 30 days and 90% of Allowable Charges thereafter per confinement Other services and supplies: 90% of Allowable Charges <i>Extended Care Facility Benefits are payable for a maximum of 180 days for any one period of disability</i> | |
| Physician | | |
| <ul style="list-style-type: none"> Surgery | 90% of Allowable Charges | 60% of Allowable Charges |
| <ul style="list-style-type: none"> Anesthesia and its administration | 80% of Allowable Charges | 60% of Allowable Charges |
| <ul style="list-style-type: none"> Hospital, office and home visits | 90% of Allowable Charges | 60% of Allowable Charges (90% of Allowable Charges for Emergency treatment rendered in the emergency room of the Hospital; see Chapter 10 for the Plan’s definition of Emergency) |
| Second surgical opinion | 100% of Allowable Charges <i>Benefit maximum of \$150 (Not subject to deductible)</i> | |

| COVERED SERVICES AND SUPPLIES | COVERAGE AMOUNT | |
|--|--|--|
| | PPO PROVIDER | NON-PPO PROVIDER |
| Annual routine physical examination • Employee and spouse | 100% of Allowable Charges <i>Benefit maximum of \$500 per person per calendar year for Physician services and for X-ray and laboratory services</i> | |
| • Children up to age 14 | 100% of Allowable Charges <i>Maximum of 16 examinations are covered on a scheduled basis</i> | |
| Maternity (female employee or legal spouse only) | Hospital and medical services and supplies are covered on the same basis as for an illness | |
| Diagnostic x-ray and laboratory (pre-authorization recommended for MRI or CAT scan to possibly save you money) | 90% of Allowable Charges | 60% of Allowable Charges |
| Durable medical equipment, corrective appliances, eligible orthotic devices and artificial limbs or eyes (pre-authorization recommended to possibly save you money) | 90% of Allowable Charges | 60% of Allowable Charges |
| Immunizations | 90% of Allowable Charges | 60% of Allowable Charges |
| Hearing aids | 90% of Allowable Charges | 60% of Allowable Charges <i>Maximum payment of \$300 for all hearing aids during a 36 consecutive month period</i> |
| Physical therapy – Outpatient (pre-authorization recommended to possibly save you money) | 90% of Allowable Charges | 60% of Allowable Charges <i>Maximum Allowable Charge for one therapy session is \$60</i> <i>Benefits are payable for a maximum of 20 sessions per calendar year for both PPO & Non-PPO</i> |
| Speech therapy - Outpatient (pre-authorization recommended to possibly save you money) | 90% of Allowable Charges | 60% of Allowable Charges <i>Maximum benefit for one therapy session is \$40</i> <i>Benefits are payable for a maximum of 130 sessions per lifetime for both PPO & Non-PPO</i> |
| Chiropractic care | Benefit of \$10 per visit for a maximum of 24 visits per calendar year | |
| Ambulance | <i>Maximum Allowable Charges are a base fee of \$700 and \$15 per mile for ground ambulance and a base fee of \$5,000 and \$70 per mile for an air ambulance</i> | |

| COVERED SERVICES AND SUPPLIES | COVERAGE AMOUNT | |
|---|--|--|
| | PPO PROVIDER | NON-PPO PROVIDER |
| Nursing care/home health care (pre-authorization recommended to possibly save you money) | 90% of Allowable Charges | 60% of Allowable Charges <i>Maximum Allowable Charge for a Registered Nurse is \$120 per visit; maximum Allowable Charge for a vocational nurse is \$60 per visit</i> |
| Hospice care (pre-authorization required) | 100% of Allowable Charges for Custodial Care, up to a lifetime benefit of \$7,500 | |
| Psychometric testing and biofeedback services | 90% of Allowable Charges for a maximum of 8 hours per disability for psychometric testing and four visits per disability for biofeedback services | |
| Psychiatric Care | | |
| <ul style="list-style-type: none"> In-patient including partial confinement (pre-authorization required for partial confinement and recommended for full-time confinement) | 50% of Allowable Charges for a maximum of 31 days per calendar year for full-time and partial confinement combined | |
| <ul style="list-style-type: none"> Out-patient professional | 80% of Allowable Charges, up to \$60 in benefits per visit for a maximum of 60 visits per calendar year No benefit payable for out-patient psychiatric facilities | |
| Substance Abuse | 80% of Allowable Charges, up to a lifetime benefit of \$5,000 in or out of Hospital | |
| Other covered medical services | 90% of Allowable Charges | 60% of Allowable Charges |

Prescription Drug Benefits for Those Enrolled in the Fee-for-Service Medical Option

Walk-in purchase at a participating pharmacy (30-day supply maximum):

- | | |
|---|--|
| <ul style="list-style-type: none"> Generic | You pay \$10 per prescription or refill |
| <ul style="list-style-type: none"> Brand name on the Formulary list (see Glossary) when no generic is available | You pay \$30 per prescription or refill |
| <ul style="list-style-type: none"> Brand name on Formulary when generic is available | If you or your doctor indicate “Do Not Substitute” on the prescription, you pay \$30 per prescription or refill, plus the cost difference between the brand name and the generic |

| COVERED SERVICES AND SUPPLIES | COVERAGE AMOUNT |
|---|--|
| <ul style="list-style-type: none"> • Non-Formulary brand name | <p>You pay \$50 per prescription or refill (if a generic is available but you or your doctor indicate “Do Not Substitute” and a brand name is dispensed, you also pay the cost difference between brand name and the generic)</p> |
| <p>Walk-in purchase at other pharmacy (30-day supply maximum)</p> | <p>The Trust will pay 90% of what it would have paid had the prescription been filled at a participating pharmacy less a member co-payment of \$50 per prescription or refill</p> |
| <p>Purchase from mail service pharmacy (90-day supply maximum)</p> <ul style="list-style-type: none"> • Generic | <p>You pay \$20 per prescription filled or refilled</p> |
| <ul style="list-style-type: none"> • Brand name on Formulary when no generic is available | <p>You pay \$60 per prescription or refill</p> |
| <ul style="list-style-type: none"> • Brand name on Formulary when generic is available • Non-Formulary brand name | <p>If you or your doctor indicate “Do Not Substitute” on the prescription, you pay \$60 per prescription or refill, plus the cost difference between the brand name and the generic</p> <p>You pay \$100 per prescription or refill (if a generic is available but you or your doctor indicate “Do Not Substitute” and a brand name is dispensed, you also pay the cost difference between brand name and the generic)</p> |

| COVERED SERVICES AND SUPPLIES | COVERAGE AMOUNT |
|---|---|
| Vision Care Benefits Under the Spectera Vision Care Program for All Eligible Participants Except Those Enrolled in Kaiser | |
| <ul style="list-style-type: none"> • Frequency of services/materials • Spectera Network | <p>Exam and lenses once every 12 months</p> <p>Frame once every 24 months</p> <p>When you use a network provider your eye exam and most eyewear is covered in full after member co-pay:</p> <p>\$10 co-pay for exam</p> <p>\$20 co-pay for lenses or frame and lenses</p> |
| <p>Benefit allowances when you use a provider outside Spectera’s network</p> <ul style="list-style-type: none"> • Allowances for Exam • Benefit for a frame • Allowances for lenses (per pair) | <p>Out of Network claims must be submitted to Spectera</p> <p>\$40</p> <p>\$65</p> <p>\$40 single vision</p> <p>\$60 bifocals</p> <p>\$80 trifocals</p> |
| <ul style="list-style-type: none"> • Allowances for contact lenses (per pair) | <p>\$125 lenticular</p> <p>\$210 if necessary following cataract surgery and under other specific conditions</p> <p>\$125 for cosmetic reasons; the \$125 allowance is in lieu of benefits for lenses and a frame</p> |

| Dental Benefits for Those Enrolled in the Fee-for-Service Dental Option | |
|--|--|
| <p>Services other than orthodontia</p> | <p>100% of scheduled allowances (See Chapter 5 for fee schedule)</p> <p><i>Maximum benefit of \$1,500 per person per calendar year</i></p> |
| <p>Orthodontia (children only)</p> | <p>50% of banding charges up to a maximum payment of \$800, 50% of monthly adjustment charges up to a maximum payment of \$100</p> <p><i>Maximum lifetime benefit of \$1,500 per child</i></p> |

| |
|----------------------|
| FILING CLAIMS |
|----------------------|

Information on how to file claims is included at the end of each of the Chapters describing the individual benefits. For information on what to do if you disagree with the decision made in regard to your claim, see “Claims Review Procedures” in Chapter 10, “Other Important Plan Information.”

Chapter 1

PARTICIPATING IN THE PLAN

In this Chapter you'll find:

- Eligibility
- Enrollment
- Coverage during family or medical leave
- When eligibility terminates
- COBRA continuation coverage
- Certificate of creditable coverage

The eligibility rules described in this booklet apply to all the benefits provided under the Plan to employees and their families, including the fee-for-service, HMO and DMO plans.

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 PRIOR TO THE DATE YOUR ELIGIBILITY WILL BEGIN. OTHERWISE, YOU WILL HAVE NO MEDICAL OR DENTAL COVERAGE. IN GENERAL, THE HMOS AND DMOS DO NOT ALLOW COVERAGE TO BE RETROACTIVE.

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 goes by 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.

Active Carpenters

To establish eligibility and become an Eligible Individual during an *eligibility quarter*, you must work for Contributing Employers at least 300 hours in the immediately preceding *work quarter* as follows:

| Work Quarter | Eligibility Quarter |
|--|--|
| If you work 300 hours during the months of: | You have coverage during the 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 |

If you work more than 300 hours during a work quarter, the excess hours will be credited to a reserve account (sometimes called a “bank”) established for you, up to a reserve account maximum of 600 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 300 hours. Your reserve account must be applied in this manner and is reduced by any hours used to meet the 300-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:

- 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;
- 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;
- 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;
- immediately, 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 or enrollment card is submitted to the Administrative Office.

If your work hours are divided between work for Contributing Employers under this Trust and work for contributing employers under other trusts, see the box about “Reciprocity” on the next page.

Alternate Eligibility Rules for Active Carpenters

Certain Collective Bargaining Agreements call for immediate 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 your local union or your employer.)*

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:

- 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.
- All enrollment forms must be completed and submitted to the Administrative Office prior to coverage.
- You will be eligible for coverage during subsequent months only if you meet the requirements set forth in the Collective Bargaining Agreement.
- Once you have worked 300 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.

Active Carpenters Who Become Disabled

If, as a result of illness or injury, an active Carpenter becomes disabled so as to be unable to perform the regular and customary duties of his occupation during a work quarter, he may be credited, in that work quarter and the immediately following work quarter, disability hours at the rate of 8 hours for each day he is disabled, excluding Saturdays, Sundays and holidays.

The maximum number of disability hours that can be credited to you during a work quarter is 300, less the number of hours you actually worked during that quarter. Disability hours credit can be given for a maximum of two consecutive work quarters.

In order for an active Carpenter to qualify for disability hours credit, all of the following requirements must be met:

- the disabled status must be certified by a Physician who is a medical doctor,
- **the written certification of the disabled status must be submitted to the Administrative Office not later than 90 days following the date the active Carpenter became disabled,**
- the active Carpenter must have been credited with hours worked for reasons other than having been disabled or qualified family or medical leave within the 90-day period ending on the date he became disabled, and
- the active Carpenter must have been eligible on a non-self pay basis and without the use of disability hours credit during both of the two consecutive eligibility quarters ended immediately prior to the commencement of the work quarter in which he became disabled.
- In the event that you become disabled, notify the Administrative Office in writing of this fact at once. The Administrative Office will let you know what information is required in order for you to be given proper credit for the time lost from work as a result of disability.
- Must not be receiving a Pension Benefit from the Southwest Carpenter Pension Trust.

Reciprocity

Reciprocal agreements are in effect between this Trust and other trusts covering Carpenters in certain areas (“related plans”). Under the 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 he would be ineligible in the absence of such agreements.

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 will be 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 \$500 is transferred from this Trust to a related plan on behalf of a Carpenter and the contribution rate is \$4.00 under the related plan receiving the \$500 then the Carpenter would be credited with 125 hours under that related plan (\$500 divided by \$4.00 = 125).*

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 shall continue until the carpenter has revoked the reciprocity request in writing and request is received by his home fund.

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.

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 Trust benefits in accordance with the applicable provisions of the Plan Document. You may obtain a copy of the Plan Document, at no cost, from the Administrative Office. If you are a Special Class Employee, refer to the description following the Glossary for a summary of your eligibility requirements, if different than described in the Overview of Eligibility appearing earlier in this Chapter.

Eligible Dependents

Please note that in order to establish coverage for Dependents, you must provide certain documents to the Administrative Office. See “How to Make Your Plan Selections” in the “Enrollment” section below for a list of the documents.

The following Dependents may be covered under the Plan:

- Your lawful spouse (if you are legally separated from your spouse, she or he is not eligible). A domestic partner of an Eligible Individual who is not a lawful spouse of such Eligible Individual will not be an Eligible Individual under the Plan.
- **Your unmarried children.** These can be your natural children or dependent stepchildren, foster children, or children you’ve adopted or who have been placed with you for adoption. A child cannot be eligible as a Dependent past the last day of the year in which the child became 18, or the last day of the year in which the child became 23 if a full time student at an accredited institution of learning. Except in cases of divorce or separation, a child’s official principal place of abode must be with you more than half the year, and the child must not be providing the majority of his or her own support. A child meeting the requirements of the preceding sentence can remain a Dependent after the last day of the calendar year in which the child attains 18 until the child’s 19th birthday, even if not a full time student, if you provide more than one half the child’s support in that subsequent year.

In the case of your divorce, or separation (by written agreement or physical separation for more than six months of the year), the requirement that the child’s abode be with you need not be met, if (i) you and the child’s other parent provide the majority of the child’s support together, and (ii) if one or both of you have custody of the child for the majority of the time. If the foregoing requirements are met by a Qualified Medical Child Support Order (QMCSO) the child covered

by the QMCSO will also be considered an eligible Dependent for medical coverage. (For information on the Plan's procedures regarding QMCSOs, contact the Administrative Office.)

Finally, your 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 months, can be covered as a Dependent after age 18 while such condition exists, provided such Dependent was an eligible Dependent under the plan at the time coverage would otherwise terminate due to age. 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.

IMPORTANT NOTE: Any spouse or child that is eligible under the Trust as an employee (carpenter or special class employee) can not also be eligible as a Dependent. Nor can children be covered as Dependents of more than one employee (carpenter or special class employee) under the Trust. See the definition of "Dependent" in the Glossary at the end this booklet for more detailed information on the requirements for Dependent status.

Eligibility Dates for Dependents

Your Dependents (as defined in the Glossary of this booklet, other than Dependents of Special Class Employees who have become participants) will become eligible on the later of:

- the date you become an Eligible Individual or
- 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 shall not become eligible before the first day of the first month following the employee's acquisition of the Dependent, unless acquisition is by birth.

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 of time 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 30 days of the event. Otherwise, coverage will be delayed or, in the case of divorce, you will be responsible for any costs the Trust incurs on behalf of your former spouse. A listing of required documentation can be found on page 20.

Family status forms are available from the Administrative Office.

ENROLLMENT

Choice of Coverage

Various medical and dental 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.

NOTE: Regardless of which medical and dental option you are enrolled in, as long as you are Eligible Individuals, you and your Dependents will be covered under the life insurance, and you will be covered under the accidental death and dismemberment benefits and weekly disability benefits if you are a Carpenter and meet that benefits eligibility criteria, described in this booklet. However, life insurance, accidental death and dismemberment benefits and weekly disability benefits are not provided to persons who are Eligible Individuals by reason of the COBRA continuation coverage discussed later in this Chapter.

Medical Care Options

The medical care options are as follows:

- The "**Fee-For-Service**" **Medical Option** provided directly by the Trust. If you are enrolled in the Fee-For-Service Medical Option, you and your eligible Dependents are covered for hospital, medical, vision and prescription drug services and supplies as described in Chapter 2 of this booklet.

The Fee-For-Service Medical Option is available in all geographical locations but is not available to "newly eligible"

Carpenters or Special Class Employees (unless their primary residence is outside an HMO service area). 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. An exception is made for Carpenters and Special Class Employees that enter full-time active duty in the Uniformed Services of the United States. If they were Eligible Individuals immediately prior to entering such active duty, they will not be considered to be “newly eligible” when their benefits are reinstated as described under “Military Service” later in this Chapter.

The Fee-For-Service Medical Option is only available after a Carpenter or Special Class Employee has been an Eligible Individual continuously for 12 months. After satisfaction of the 12-month requirement, a Carpenter or Special Class Employee may enroll in the Fee-for-Service Medical Option during the next regularly scheduled open enrollment period as described later in this Chapter.

- **Kaiser**, a program of managed medical care provided through Kaiser Permanente, a health maintenance organization (“HMO”). If you are enrolled in the Kaiser option, you and your eligible Dependents are covered under Kaiser for hospital, medical, vision and prescription drug services and supplies as described in Kaiser’s benefit booklet. Generally Kaiser provides its benefits through its own facilities.

Kaiser is available in most areas of Southern California and some areas in Northern California.

- **PacifiCare**, a program of managed medical care provided through PacifiCare, a health maintenance organization (“HMO”). If you are enrolled in PacifiCare, you and your eligible Dependents are covered under PacifiCare for hospital, medical and prescription drug services and supplies as described in PacifiCare’s benefit booklet. You may also utilize the Plan’s vision care discounts as described in this booklet.

PacifiCare is available in most areas of California and in the Maricopa, Pinal and Pima counties of Arizona.

- **Health Plan of Nevada**, a program of managed medical care provided through Health Plan of Nevada, a health maintenance organization (“HMO”). If you are enrolled in HPN, you and your eligible Dependents are covered under HPN for hospital, medical and prescription drug services and supplies as described in HPN’s benefit booklet.

Health Plan of Nevada is available in Washoe County and Southern Nevada only.

- **Hometown Health**, a program of managed medical care provided through Hometown Health, a health maintenance organization (“HMO”). If you are enrolled in Hometown Health, you and your eligible Dependents are covered under Hometown Health for hospital, medical and prescription drug services and supplies as described in Hometown Health’s benefit booklet.

Hometown Health is available in Northern Nevada only.

- **Intermountain Health Care (IHC)**, a program of managed medical care provided through IHC Health Plan, a health maintenance organization (“HMO”). If you are enrolled in IHC, you and your eligible Dependents are covered under IHC for hospital, medical and prescription drug services and supplies as described in IHC’s benefit booklet.

IHC is available in Utah only.

Dental Plan Options

The three dental care options are as follows:

- The “**Fee-For-Service**” **Dental Option** provided directly by the Trust as described in this booklet.

As with medical, the Fee-For-Service Dental Plan is available in all geographical locations but is not available to “newly eligible” (as described above) active Carpenters or Special Class Employees (unless their primary residence is outside all DMO service areas). Once you meet the 12-month rule described above under the Fee-For-Service Medical Option, you are also eligible to enroll in the Fee-For-Service Dental Option. In some areas, the Trust maintains a listing of panel dentists. Using one of these providers can limit your out of pocket costs.

- **Pacific Union Dental**, a program of managed dental care provided through Pacific Union Dental as described in Pacific Union Dental’s (or its affiliate’s) benefit booklet.

Pacific Union Dental is available in most areas of California.

- **Golden West**, a program of managed dental care provided through Golden West as described in Golden West’s benefit booklet.

Golden West is available in most areas of California

- **Employers Dental Services (EDS)**, a program of managed dental care provided through EDS as described in EDS’s benefit booklet.

EDS is available in certain areas of Arizona

- **Total Dental Administrators (TDA)**, a program of managed dental care provided through TDA as described in TDA’s benefit booklet.

TDA is available in Arizona and Utah

- **Nevada Pacific Dental (NPD)**, a program of managed dental care provided through NPD as described in NPD’s benefit booklet.

NPD is available in Nevada only.

When to Make Your Coverage Selections

You are given the opportunity to make your selections among available options when you first become eligible for benefits from the Plan and Trust. Once enrolled in the options you have selected, you may change your selection only during the Trust’s annual open enrollment period. Each year the Administrative Office will notify you of the Trust’s open enrollment period. However, you may also change your selection if you are enrolled in an HMO and/or DMO and you move away from its 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 coverage selections as of the date you reestablish eligibility under the Plan, provided two consecutive eligibility quarters have not elapsed.

The HMO and DMO 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, dental, vision or prescription drug benefits until enrollment forms are received.**

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

Documentation for Dependents

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

- for your spouse, a certified copy of your marriage certificate
- for your natural children, a certified copy of their birth certificates
- for your adopted or foster children, a certified copy of the adoption papers or court order showing your legal responsibility for each child
- for your step-children, a certified copy of their birth certificates (note: in order to enroll step-children, a certified copy of your marriage certificate is required)
- for your children between the ages of 19 and 23 and attending school full time (12 units), a completed student certification form for each child (this form can be obtained from the Administrative Office)
- For children for whom you are legally responsible for providing health coverage, a copy of the Qualified Medical Child Support Order

In order to establish coverage for Dependents, you **must provide** the documents listed above to the Administrative Office. It is your obligation to cooperate with the Administrative Office in providing such information.

Frequently Asked Questions

Q Do I have to take a physical exam to enroll in benefits?

A No, a medical examination is not required. Eligible Individuals will be covered regardless of their physical condition.

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.

Beneficiary Card

Every employee who is working for a Contributing Employer should complete a life insurance beneficiary card. 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 his life insurance and accidental death benefits. 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 Prudential 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 Have Coverage Elsewhere

If you or your Dependents 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 “Medicare and Plan Benefits” and “Coordination of Benefits and Reimbursement Obligation” in Chapter 10 for more information. Also, no individual may be covered under any of Trust’s benefit programs as both an employee and as a dependent or as a dependent of more than one employee.

COVERAGE DURING A FAMILY OR MEDICAL LEAVE

The Family and Medical Leave Act of 1993 (FMLA) entitles certain eligible employees to take up to 12 weeks 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.

For more information on the FMLA, contact your employer.

WHEN ELIGIBILITY TERMINATES

Termination or Amendment of the Plan

An individual will cease to be an Eligible Individual effective on the date of the complete termination of the Plan or upon the effective date of an amendment to the Plan which excludes such individual from coverage under the Plan.

Active Carpenters

An active Carpenter’s Plan eligibility, and therefore his 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 his/her reserve account, do not total at least 300 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 has been established for both medical and dental plans based on enrollment information received by the Administrative Office and 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 his status as an Eligible Individual, will terminate in accordance with the applicable provisions of the Plan document, which generally will be the last day of the calendar month in which the employee ceases to be a member of an eligible Special Class Employees.

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

Military Service

If an Eligible Individual who is an employee enters full-time active duty in the Uniformed Services of the United States, such individual and his Dependents shall cease to be Eligible Individuals unless such Eligible Individual submits a written election to continue health coverage to the Administrative Office within 60 days of entering the Uniformed Services full-time. The maximum period such an employee and employee’s Dependents shall continue to be Eligible Individuals as a result shall be the lesser of:

- the 24-month period beginning on the date the Eligible Individual’s Uniformed Services absence begins; or
- the period ending the day after the date on which the Eligible Individual fails to return to work for a Contributing Employer, as determined under Section 4312(e) of the Uniformed Services Employment and Reemployment Rights Act of 1994.

Those employee Eligible Individuals that elect to continue health coverage for themselves during Uniformed Services absence and/or their Dependents must pay for the continuation coverage. Payment shall be in the same amount and form as that made for COBRA continuation coverage. Please note that life insurance, accidental death and dismemberment coverage and weekly disability benefits cannot be continued. For more information, see “Cost and Payment of COBRA Continuation Coverage” under “COBRA Continuation Coverage” later in this Chapter.

The employee will be reinstated as a regular Eligible Individual as of the first day of reemployment, provided he returns to work for a Contributing Employer within 90 days from discharge from full-time active duty. An active Carpenter that loses eligibility as a result of entering the Uniformed Services shall have the hours in his reserve account preserved until the active Carpenter returns to work, provided he is reemployed by a Contributing Employer within 90 days of discharge.

NOTE: Dependents who enter the Uniformed Services cannot continue their benefits—they are ineligible for benefits under the Trust.

Dependents

A Dependent’s Plan eligibility will terminate, and therefore he or she will cease to be an Eligible Individual, on the earliest of the following dates:

- the date the Dependent no longer meets the definition of a Dependent, or
- the date the employee from whom the Dependent derives Dependent status ceases to be an Eligible Individual (*in the event of an active Carpenter’s death, however, his Dependent’s eligibility will continue for the period such active Carpenter would have remained eligible based upon his work hours accumulated at his death*).

In either case, legislation known as COBRA gives the Dependent the option of temporarily continuing health care coverage at his own expense. See “COBRA Continuation Coverage” later in this chapter for more information.

If your Dependent child is incapable of self-sustaining employment by reason of physical handicap or mental retardation on the date his/her eligibility would otherwise terminate because of age, coverage may be continued for the Dependent if certain requirements are met. Contact the Administrative Office for more details on this extension.

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 continuation coverage. 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 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 would otherwise end because of a “qualifying event.” Under a federal law known as “COBRA,” continuation coverage must be offered to each person who is a “qualified beneficiary.” A qualified beneficiary is someone who will lose coverage under the Plan because of a “qualifying event.” Depending on the type of qualifying event, employees, spouses of employees and dependent children of employees may be qualified beneficiaries. 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 after a qualifying event.

COBRA Eligibility (COBRA-Qualifying Events)

For Employees

If you are an employee, COBRA continuation coverage is available to you if coverage would otherwise 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 would otherwise 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 his or her 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 would otherwise 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 his or her 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.”

Considerations for Retiring Carpenters

If an active Carpenter’s Plan coverage is terminating due to retirement and he is entitled to elect coverage under the Trust’s Retiree Health Plans (for himself, his Dependents or both) in accordance with the eligibility rules for retired Carpenters, he may elect coverage under either one of the Retiree Health Plans or this COBRA continuation coverage for those individuals who qualify for both.

If he elects coverage under the Trust’s Retiree Health Plan, all those enrolled in the Retiree Health Plan will forfeit their rights to this COBRA continuation coverage. If he elects COBRA continuation coverage, all those enrolled in the continuation coverage will forfeit their rights to coverage under the Trust’s Retiree Health Plans, even after COBRA continuation coverage expires.

Type of COBRA Continuation Coverage

COBRA continuation coverage includes all current health benefits under the Trust for active Carpenters and Dependents (medical, prescription drug, vision care and dental). It does NOT include life insurance, accidental death and dismemberment benefits or weekly disability benefits.

You and your Dependents may each choose independently whether or not to continue coverage under COBRA.

Option Selection

A COBRA participant can continue coverage only under the options he was enrolled in as of the date his coverage would have otherwise ended. He can change his coverage options 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 medical option and the Pacific Union Dental option as of the date his coverage would otherwise end can continue coverage only under those options until the next annual open enrollment period. Exceptions are made only if someone is enrolled in an HMO or DMO and moves out of the service area.

Notification Requirements

Divorce or Legal Separation or a Child's Losing Dependent Status

The Trust will offer COBRA continuation coverage to qualified beneficiaries only after the Administrative Office has been notified that a qualifying event has occurred. When the qualifying event is divorce or legal separation of the employee and spouse or a Dependent child's losing eligibility for coverage, the active Carpenter, Special Class Employee, spouse or other Dependent must notify the Administrative Office in writing of a divorce or legal separation or a child's losing Dependent status under the Trust **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 must be received at one of the following addresses:

California:
533 South Fremont Avenue
Los Angeles, CA 90071-1706
(213) 386-8590

Arizona:
4547 W. Mc Dowell Rd.
Phoenix, AZ 85035-4121
(602) 352-6805

Utah:
8149 S. Welby Park Dr.
West Jordan, UT 84088
(801) 282-6528

Nevada:
980 Kelly Johnson Drive, Suite 180
Las Vegas, NV 89119
(702) 851-4510

If the Administrative Office is not notified in writing within 60 days, the participant(s) whose coverage under the Trust is terminating will not be entitled to continue coverage under this special extension.

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 also suggested that a family member contact the Administrative Office in the event of the death of the employee.)

The Administrative Office shall determine if there has been a termination of employment or reduction of hours that would qualify an active Carpenter for COBRA continuation coverage.

Enrollment Requirements

When the Administrative Office is notified of a qualifying event, the necessary forms for enrollment in COBRA continuation coverage will be mailed to the participant.

A COBRA participant can enroll in the continuation coverage by completing the “Election/Rejection” form provided to him by the Administrative Office **within 60 days** from

- the date coverage would otherwise terminate, or
- the date the Administrative Office mailed the Election/Rejection form to the participant (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 Trust is terminating will not be entitled to continue coverage under this special extension except as provided under “Special COBRA Enrollment Rights” starting on page 27.

Duration of COBRA Continuation Coverage

For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date coverage under the Trust would otherwise have been lost.

COBRA Continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee eligible Individual, his or her 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 of the employee Eligible Individual’s hours of employment, COBRA continuation coverage lasts for up to 18 months. There are three ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Trust 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.**

Medicare Entitlement extension of 18-month period of continuation coverage

If the employee Eligible Individual became entitled to Medicare within the 18 month period preceding the date of the qualifying event, his spouse and dependent children (but not the employee) can get additional months of COBRA continuation coverage, up to a maximum of 36 months measured from the date the employee Eligible Individual became entitled to Medicare.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. 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 Trust 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.**

Cost and Payment of COBRA Continuation Coverage

COBRA participants must pay for 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 participants.

Options for Payment

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

Initial Self-Payment

The initial self-payment for continuation coverage must be submitted to the Administrative Office **within 45 days** from the COBRA participant's election date. The initial payment must cover the number of months from the date coverage would otherwise 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
533 South Fremont Avenue
Los Angeles, CA 90071-1706

Or, for Nevada participants:

Southwest Carpenters Health and Welfare Trust
980 Kelly Johnson Drive, Suite 180
Las Vegas, NV 89119

If the initial self-payment in the proper amount is not submitted to the Administrative Office within the 45-day period described above, the election of continuation coverage shall 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 this special extension.

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

After the initial self-payment is made as outlined above, self-payments must be made monthly to continue coverage. Monthly payments should be mailed 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 payment within 30 days of the beginning of the coverage month, continuation coverage will terminate as of the end of the period for which payment has been made. Once terminated, 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 participant to submit payments when due. The Administrative Office will, however, notify you in writing when your COBRA continuation coverage terminates.

Special COBRA Enrollment Rights

Open Enrollment

The Open Enrollment period is held during one month of each year (CSAC mails an announcement of when the open enrollment period will occur). At such time you may change your medical or dental coverage, your coverage type, add or delete qualified beneficiaries, or change your coverage between family and individual.

New Dependent(s) Acquired Under COBRA

If you acquire a new dependent through marriage, birth, or placement for adoption while you are enrolled in COBRA continuation coverage, you may add that dependent to your coverage for the balance of your COBRA coverage period. For example, if you have five months of COBRA left and you get married, you can enroll your new spouse for five months of COBRA coverage.

To enroll your new dependent for COBRA coverage, you must notify the Administrative Office within 31 days of acquiring the new dependent. There may be a change in your COBRA premium amount in order to cover the new dependent. A child born to or placed for adoption with the employee while covered under COBRA will be a qualified beneficiary.

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 for coverage for the balance of the period of COBRA continuation coverage. The spouse or dependent must have been eligible for COBRA coverage, but not enrolled. When COBRA enrollment was offered and declined, the spouse or dependent must have been covered under another group health plan or had other health insurance coverage.

You must enroll the spouse or dependent *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, or 3) employer contributions toward the other coverage being terminated. 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.

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:

- The first day of the month for which you do not submit the COBRA premiums within the required time period.
- The date on which the Plan is terminated.
- 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.
- 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).
- 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
- (*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.

| Maximum Duration of Continuation Coverage for Different Qualifying Events | | |
|---|--|---|
| Qualifying Event | Who May Continue Coverage | Maximum Period of 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 die | Your spouse and/or your dependent children covered under the Plan | 36 months |
| You 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 (for example, because of marriage or a change in age or student status) | The affected dependent child who was covered under the Plan | 36 months |
| Your child ceases to meet the Plan's definition of an eligible Dependent (for example, because of marriage or a change in age or student status) | 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.</p> <p><i>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.</i></p> | | |

If You Have Questions

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/ebsa.

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, not to the other health care benefits usually available under COBRA:

- 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).

- If you are 60 years of age or older at the time of the qualifying event and have been employed with a Contributing Employer for 5 years or more and notify the HMO of your election to continue coverage within 30 days prior to the date coverage is scheduled to end. (Note: this provision expires on January 1, 2005 for older workers and their spouses who have not qualified by that date.)

To take advantage of either of these provisions, your continuation coverage must be through the same HMO plan.

For more information, contact your HMO.

Conversion to Individual Coverage (Applicable Only to HMO Participants)

Under certain circumstances, employees and eligible family members whose coverage through an HMO ends are allowed to purchase individual conversion coverage through their HMO without evidence of insurability. Individuals must apply 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 plan.

For more information, contact your HMO.

CERTIFICATE OF CREDITABLE COVERAGE

If your coverage under the Plan ends and you become eligible for a new health plan, the length of time you were covered under the Plan may be used to reduce the length of any pre-existing condition exclusion period contained in your new health plan.

When your coverage ends under the Plan, the Administrative Office will automatically mail you a certificate of creditable coverage. This certificate provides information your new health plan may need. You should check with your new plan's administrator to verify whether your new plan has restrictions on coverage of pre-existing conditions and how creditable coverage is applied under that plan. Present your certificate to your new plan so that your new plan will know to apply your creditable coverage to the pre-existing condition exclusion period under your new plan.

If you need another copy of your certificate of creditable coverage, you may request one from the Administrative Office by telephoning (800) 293-1370 or writing to:

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

Or, for Nevada participants

Southwest Carpenters Health and Welfare Trust
980 Kelly Johnson Drive, Suite 180
Las Vegas, NV 89119

The certificate will show the length of time you had coverage under the Trust including ineligible periods due to any waiting periods and/or non-receipt of required enrollment materials by the Administrative Office. The purpose of the certificate is to reduce the length of any pre-existing condition exclusion period contained in your new health plan. It can NOT be used for the purpose of claiming eligibility under the Southwest Carpenters Trust.

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.

FEE-FOR-SERVICE MEDICAL OPTION SUMMARY

In this Chapter you'll find:

- How the Fee-for-Service Medical Option works
- Annual deductible
- Stop-loss limit
- Lifetime maximum benefit
- Pre-authorization
- Special provisions regarding women's health care
- What's covered
- What's not covered
- Information on filing claims

The information in this Chapter applies to you only if you are an Eligible Individual enrolled in the Fee-for-Service Medical Option. If you are enrolled in one of the HMOs instead, see the separate booklet(s) issued by the HMO for information on your medical benefits.

HOW DOES THE FEE-FOR-SERVICE MEDICAL OPTION WORK?

In general, the Fee-for-Service Medical Option works as follows: Subject to any pre-authorization requirements (and your having met the deductible, if applicable), the Plan will pay the stated percentages of Allowable Charges until the patient's Allowable Charges total \$20,000 (the Plan's "stop-loss limit") during a calendar year, then the Plan pays 100% of Allowable Charges incurred thereafter during the same calendar year by the same individual, subject to a "lifetime maximum benefit." Note, however, that Allowable Charges for certain services and supplies do not count toward the stop-loss limits, nor will Allowable Charges for those services and supplies be covered at 100% after you reach the stop-loss limit.

Preferred Provider Organization "PPO"

As noted in the various benefit descriptions contained in this Chapter, if an Eligible Individual enrolled in the Fee-For-Service Medical Option obtains services from a PPO provider contracted with the Plan, the percentage of Allowable Charges payable by the Plan may be higher.

What Is a PPO?

"PPO" means "Preferred Provider Organization." PPO's contract with Hospitals, Physicians and other health care providers to provide eligible members with medical care at specified prices. The PPO helps you and the Trust save money.

The Trust contracts with different PPO's. Currently in California, Blue Cross Prudent Buyer Plan provides the PPO network. In Arizona, CCN provides the PPO network. Beech Street provides the PPO network in all other areas.

How Does the PPO Work?

- When you need to see a Physician, simply select one from the PPO's preferred provider listing (see box below).
- Before your appointment, call the provider's office to verify that the provider is still in the PPO network. It is recommended that you keep a record of the date, time and name of the person you spoke to.
- When you visit the PPO Physician, show the receptionist your Southwest Carpenters Health and Welfare Trust ID card **and** tell him/her that you are also covered by Blue Cross Prudent Buyer Plan (in California), CCN (in Arizona) or Beech Street (in all other areas). If you reside outside California, but use services in California, use the ID card you would

normally use. Be sure to give the physician's office staff your (the member's) Social Security Number for verification of eligibility. If you are referred to a specialist or to a Hospital, remind your Physician that you want to use PPO Physicians and/or Hospitals. If your Physician prescribes a CAT scan, MRI, durable medical equipment or home health care, have your Physician arrange the tests, equipment or care through a PPO provider. (NOTE: The Trust has direct PPO contracts with medical equipment suppliers, physical therapists, laboratories and diagnostic testing facilities (for MRI's and CAT scans) which could save you even more money. If you need any of these services or items you are **urged to request pre-authorization** from the Trust's Administrative Office so services or supplies can be arranged with one of the Trust's contracted providers. See "Pre-Authorization" 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 to.

Why Use PPO Providers?

PPO providers save you money, as follows:

- The Plan's benefit reimbursement percentages to you are generally much higher when you use a PPO provider.
- Many of the 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 stop-loss limit feature where benefits increase to 100% apply when you use a PPO Hospital. They do not apply when you use a non-PPO Hospital.
- PPO Physicians and other health care providers have agreed to provide medical services and supplies to Eligible Individuals at specified fees, which the Plan considers "Allowable Charges" thus limiting your out-of-pocket costs.
- Every PPO provider has agreed to send your claims directly to the Administrative Office. You simply give the provider the Plan's regular claim form or billing information.

Important Note

If you use a non-PPO provider, it is likely that his charges will exceed what is allowed by the Plan. Refer to the definition of Allowable Charges in the Glossary. In addition to any co-payments, you are responsible for payment of all charges in excess of Allowable Charges. This applies to any non-PPO provider used for any reason.

PPO Provider Listings

The listing of health care providers contracting with the PPO's, the Plan's preferred provider organizations, is updated periodically. To obtain a current listing of providers in your area,

- In California, visit the Blue Cross website at www.bluecrossca.com
- In Arizona, visit the CCN website at www.ccnusa.com
- In all other areas, visit the Beech Street website at www.beechstreet.com

If you need a written list of providers in your area and you don't have access to the Internet, call the Administrative Office. The staff will be happy to print off and mail you a list, free of charge.

Because the listings are updated regularly, it is very important that you check with a provider before obtaining services to verify that the provider is currently in the PPO network.

Direct Contracts

In addition to PPO contracts, the Administrative Office has direct contracts with the following providers that will save you money.

| Direct Contracts | | |
|---|------------------------------------|----------------|
| In California | | |
| • MRI and CAT-Scans | Medlink | (888) 558-0680 |
| • MRI and CAT-Scans | Diagnostic Village | (800) 939-3940 |
| • Laboratory and Pathology | Primex | (800) 961-7870 |
| • Home Medical Equipment & Medical Supplies | Ultimate Healthcare | (866) 485-8463 |
| • Home Medical Equipment & Medical Supplies | Experea Healthcare | (866) 397-3732 |
| • Home Medical Equipment, IV Therapy, Medical Supplies & Nursing Services | HomeLink | (866) 271-1811 |
| • Physical Therapy | Physical Rehabilitation Network | (877) 861-9000 |
| Outside California | | |
| • MRI and CAT-Scans | Medlink AZ, NV, UT | (888) 558-0680 |
| • Laboratory and Pathology | Primex So NV Only | (702) 258-8826 |
| • Home Medical Equipment & Medical Supplies | Ultimate Healthcare AZ, NV, UT | (866) 485-8463 |
| • Home Medical Equipment & Medical Supplies | Experea Healthcare AZ, NV, UT | (866) 397-3732 |
| • Home Medical Equipment, IV Therapy, Medical Supplies & Nursing Services | HomeLink AZ, NV, UT | (866) 271-1811 |
| • Physical Therapy | Physical Rehabilitation Network AZ | (800) 664-5240 |

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 page 100 under “Expenses Incurred Outside the United States” for more details.

WHAT IS THE DEDUCTIBLE?

The deductible is the amount of Allowable Charges you need to pay each calendar year before the Plan starts paying Allowable Charges for covered services or supplies. The Plan’s deductible is \$150 per person with a family maximum of \$450 per calendar year.

Non-covered expenses or expenses in excess of Allowable Charges may not be used to satisfy the deductible.

Services and Supplies for Which the Deductible is Waived

You do NOT have to meet the deductible before the Plan starts paying benefits for the following:

- Routine physical exams
- Second surgical opinions

End-of-Year Carryover

Any Allowable Charges 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 your meeting the deductible late in one calendar year and then having to meet it soon again in the following year.

Common Accident Deductible

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 of \$150.

WHAT IS THE STOP-LOSS LIMIT?

The stop-loss limit is \$20,000 per person per calendar year. This means that when certain Allowable Charges incurred during a calendar year by a family member reaches \$20,000, the Plan's benefit percentage for most covered services increases to 100% for the remainder of the calendar year for that family member.

The following do not count toward meeting the stop-loss limit:

- expenses applied toward the deductible
- the amounts you pay for any of the following: (nor will coverage of these items increase to 100% after you reach the stop-loss limit):
 - Non-PPO Hospital charges for in-patient and outpatient care
 - Non-PPO Ambulatory Center charges
 - Psychiatric Care
 - Substance Abuse treatment
- amounts you pay for non-covered services
- charges above what the Plan allows

WHAT IS THE LIFETIME MAXIMUM BENEFIT?

The lifetime maximum benefit is \$1 million per Eligible Individual but not more than \$7,500 for Custodial Care from a hospice program and \$5,000 for treatment of Substance Abuse, whether or not there has been an interruption in coverage or change in eligibility status. This means that no more than \$1 million (including the \$7,500 maximum for Custodial Care and the \$5,000 maximum for treatment of Substance Abuse) will be paid under the Fee-For-Service Medical option on account of each covered person. However, if benefits have been paid during a year, the amount paid up to \$1,000 will be automatically reinstated each January 1.

Additionally, if an Eligible Individual incurs Allowable Charges totaling \$200,000 or more, he can apply to the Trust for reinstatement of the full maximum benefit by furnishing satisfactory medical evidence of good health. Contact the Administrative Office for details on how to apply for reinstatement.

There is no reinstatement of the \$7,500 maximum benefit for Custodial Care from a hospice program or the \$5,000 maximum benefit for treatment of Substance Abuse.

PRE-AUTHORIZATION

Pre-authorization is required for some benefits under the Fee-for-Service Medical Option. For other benefits under the Fee-For-Service Medical Option, pre-authorization is recommended because the Administrative Office can direct you to providers who will save you money. For pre-authorization of services in California contact Blue Cross at (800) 274-7767. For pre-authorization of services outside California contact the Trust's Administrative Office at (800) 252-9255.

Required Pre-Authorization

Required pre-authorization means that the Administrative Office must be given certain information to determine whether or not proposed treatment will be covered under the Plan and the Administrative Office must give authorization in writing for the treatment, as provided below, BEFORE the treatment is rendered.

The following services and items *require* pre-authorization (that is, no benefits are payable for covered services and supplies unless pre-authorization has been obtained):

- Partial hospitalization in connection with Psychiatric Care
- Hospice care
- Hospital and anesthesia services in connection with dental care

Voluntary Pre-Authorization

Pre-authorization is not required as a condition for receipt of benefits for the following services, supplies and treatments. Nevertheless, it is recommended you seek pre-authorization regarding the following services, supplies and treatments to help you understand the type and amount of benefits that will be available, and as a means of obtaining referral to a less expensive PPO or Direct Contract provider:

- Full-time hospitalization in connection with Psychiatric Care
- Inpatient confinement in a Rehabilitation Facility
- Surgical procedures where the surgeon's fee is expected to exceed \$1,500
- Skilled nursing services
- Physical therapy services
- Speech therapy services
- Home I.V. infusion therapy
- Home uterine activity monitoring
- Durable medical equipment
- MRI's and CAT scans

The Administrative staff will advise you whether the proposed treatment or supply is covered and provide you with an explanation of the amount of benefits available to you.

How to Request Pre-Authorization

As soon as any of the listed items are proposed by your Physician, advise your provider that pre-authorization is required or recommended. There are two ways to request pre-authorization:

By telephoning: You or your provider may telephone Blue Cross (for services in California) at (800) 274-7767 or the Administrative Office (for services outside California) at (213) 385-0551 or toll-free (800) 252-9255. In Nevada call (702) 851-4510 or (800) 501-0210.

By submitting a request in writing: Have your Physician write down (on his letterhead paper) what services and/or supplies are being proposed and the reason(s) it or they are necessary. Include the patient's name and member's Social Security Number on the correspondence. Mail it (or have your provider mail it) to the Administrative Office **at least 10 days before** undergoing the proposed treatment or obtaining the proposed service or supply. You or your authorized representative can also deliver such a request to the Administrative Office in person. Any supporting documents should accompany the request.

A medical or dental consultant will review the information submitted and make a determination on whether or not the proposed care meets the Plan's requirements for payment. The Administrative staff will provide you with an explanation of benefits for the proposed care.

The health care benefits determination will ordinarily be sent to you and your provider within 15 days from the date the request for pre-authorization is received by the Administrative Office. You will then know whether or not the proposed care is covered under the Plan and the extent to which benefits will be provided at Plan expense. For more information about the time frames for responding to requests for required pre-authorizations and for information on how you can appeal if you disagree with the decision made on a required pre-authorization, see the entries for "pre-service claims" in "Claims Review Procedures" in Chapter 10.

Nature of Pre-Authorization

If you seek pre-authorization of any of the treatments, supplies or services listed above for which pre-authorization is *required*, the Administrative Office or other medical review firm will review the proposed treatment, supply or service to determine whether you are eligible for the Plan, whether the treatment is covered, and to what extent, and whether it is Medically Necessary. You will be notified of the conclusion as to whether the Plan will cover the treatment or service. If denied, the denial will be in writing and explain the reasons, and this will be a denial of a claim which can be appealed under the Claims Review Procedures described in Chapter 10. If you seek pre-authorization that is *voluntary*, the Administrative Office will give you its interpretation as to the available coverage for the treatment, supply or service under the Plan. Such interpretation is not binding on you or the Plan, however. You can then decide whether to obtain the treatment or service. The decision to get treatment, supplies or services will be between you and your health care provider alone. You may thereafter make a claim for coverage which will be newly considered as a claim without regard to the voluntary pre-authorization advice given to you.

SPECIAL PROVISIONS REGARDING WOMEN'S HEALTH CARE

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).

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 mastectomy, including lymph edemas. These services are elective and are chosen by the patient in consultation with the attending Physician. They are subject to the Plan's usual deductible and co-payment provisions.

WHAT IS COVERED?

Covered services and supplies are described below.

These services and supplies are covered under the Plan only if they are certified by the attending Physician and determined by the Trust to be Medically Necessary, except as specifically provided otherwise. Further, only Allowable Charges for covered services and supplies will be considered when determining benefits under the Plan. Refer to page 108 for the definition of Allowable Charges.

NOTE: Pre-authorization is required for certain services. Voluntary pre-authorization is recommended for others. See "Pre-Authorization" earlier in this Chapter.

HOSPITAL SERVICES

The Hospital benefits described below do not apply to Psychiatric Care or treatment of Substance Abuse. Separate benefits are provided for these conditions. Refer to the benefits for Psychiatric Care and Substance Abuse treatment in the following pages.

Need to Go to the Hospital?

The Plan will pay more of the bill if you are confined in a PPO Hospital than it would if you were confined in another Hospital. Refer to “How Does the Fee-For-Service Medical Option Work?” on page 30 for information on the PPO.

IN-PATIENT CONFINEMENT IN A PPO HOSPITAL

If an Eligible Individual is a registered bed patient in a PPO Hospital, the Plan will pay 90% of the Hospital’s charges for room and board (including confinement in an intensive care or coronary unit) and other Medically Necessary services and supplies furnished by the Hospital

IN-PATIENT CONFINEMENT IN A NON-PPO HOSPITAL

(Not included in the Plan’s stop-loss limit feature)

If an Eligible Individual is a registered bed patient in a non-PPO Hospital, the Plan will pay 60% of Allowable Charges to the extent billed by the Hospital for room and board (including confinement in an intensive care or coronary unit) and other Medically Necessary services and supplies furnished by the Hospital (subject to the “Limits on Allowable Charges” referenced below).

Limits on Allowable Charges: Any additional cost for a private room is not covered by the Plan.

OUT-PATIENT SERVICES IN A PPO HOSPITAL

If an Eligible Individual is not confined in a Hospital as a registered bed patient but incurs expenses for treatment in the out-patient department of a PPO Hospital, the Plan will pay benefits as follows:

90% of the PPO Hospital’s charges in connection with surgery

after you pay a co-payment of \$50, 90% of the PPO Hospital’s charges in connection with emergency room care that normally cannot be performed in a Physician’s office. A medical emergency must exist in order for this benefit to be paid. A medical emergency is the sudden unexpected onset of a medical condition, not normally treatable in the provider’s office, that manifests itself by acute symptoms of enough severity that urgent and immediate medical attention is required without regard to the hour of day or night to prevent significant impairment in bodily functions or serious and/or permanent damage to any bodily organ or part.

90% of the PPO Hospital’s Allowable Charges in connection with other Medically Necessary out-patient department treatment

Please note that charges for Physician services are not payable under this section of the Plan. Refer to the benefit descriptions for Physician services on the following pages.

OUT-PATIENT SERVICES IN A NON-PPO HOSPITAL

(Not included in the Plan’s stop-loss limit feature)

If an Eligible Individual is not confined in a Hospital as a registered bed patient, but incurs expenses for treatment in the out-patient department of a non-PPO Hospital, the Plan will pay benefits as follows (**subject to the “Limits on Allowable Charges” referenced below**).

60% of the Hospital’s charges in connection with surgery

after you pay a co-payment of \$50, (90% of the Hospital’s charges in connection with emergency room care that normally cannot be performed in a Physician’s office.) Benefits for emergency room services are paid at the PPO rate only if a medical emergency exists. A medical emergency is the sudden unexpected onset of a medical condition, not normally treatable in the provider’s office, that manifests itself by acute symptoms of enough severity that urgent and immediate medical attention is required without regard to the hour of day or night to prevent significant impairment in bodily functions or serious and/or permanent damage to any bodily organ or part.

60% of the Hospital’s Allowable Charges in connection with other Medically Necessary out-patient department treatment

Limits on Allowable Charges: Allowable Charges for non-PPO facilities are limited to \$5,000 per operative session for surgery-related services and supplies and \$3,500 per visit for other services and diagnostic procedures (emergency room care and other Medically Necessary care).

Please note that charges for Physician services are not payable under this section of the Plan. Refer to the benefit descriptions for Physician services on the following pages.

NOTE: IT IS STRONGLY RECOMMENDED THAT YOU GET A COST ESTIMATE FROM THE HOSPITAL IN NON-EMERGENCY SITUATIONS SINCE THE PLAN HAS LIMITS ON ALLOWABLE CHARGE

NOTE: IT IS STRONGLY RECOMMENDED THAT YOU GET A COST ESTIMATE FROM THE HOSPITAL IN NON-EMERGENCY SITUATIONS SINCE THE PLAN HAS LIMITS ON ALLOWABLE CHARGES

**INPATIENT SERVICES
IN A PPO
REHABILITATION
FACILITY**

(Pre-authorization is recommended for this benefit. Refer to “Pre-Authorization” earlier in this chapter)

If an eligible individual is confined in a PPO Rehabilitation Facility as a registered inpatient for rehabilitation from a severe medical condition such as a stroke or head trauma, the Plan will pay 90% of Allowable Charges for room and board and other Medically Necessary services and supplies including but not limited to, physical and speech therapy.

Inpatient Rehabilitation Facility benefits are payable for a maximum of 30 days per calendar year (PPO and non-PPO combined).

If services are rendered on an outpatient basis, refer to the benefit descriptions for outpatient physical therapy and speech therapy on the following pages.

**INPATIENT SERVICES
IN A NON-PPO
REHABILITATION
FACILITY**

(Pre-authorization is recommended for this benefit. Refer to “Pre-Authorization” earlier in this chapter)

If an eligible individual is confined in a non-PPO Rehabilitation Facility as a registered inpatient for rehabilitation from a severe medical condition such as a stroke or head trauma, the Plan will pay 60% of Allowable Charges for room and board and other Medically Necessary services and supplies including but not limited to, physical and speech therapy.

Inpatient Rehabilitation Facility benefits are payable for a maximum of 30 days per calendar year (PPO and non-PPO combined).

If services are rendered on an outpatient basis, refer to the benefit descriptions for outpatient physical therapy and speech therapy on the following pages.

**SURGICAL SERVICES
IN A PPO
AMBULATORY
CENTER**

**NOTE: IT IS STRONGLY
RECOMMENDED THAT YOU
GET A COST ESTIMATE
FROM THE AMBULATORY
CENTER SINCE THE PLAN
HAS LIMITS ON ALLOWABLE
CHARGES**

(Not included in the Plan’s stop-loss limit feature)

If an Eligible Individual undergoes a surgical procedure in a PPO Ambulatory Center that is accredited by the Accreditation Association for Ambulatory Health Care, Inc. or licensed by the state in which the center is located, the Plan will pay 90% of Allowable Charges made by the Ambulatory Center for services and supplies in connection with the surgery.

Please note that the facility must meet the Plan’s definition of an Ambulatory Center (refer to page 108) in order for the preceding benefits to be paid. If the facility does not meet the Plan’s definition, benefits are payable at 90% up to a maximum payment equal to 10% of the amount payable to the surgeon for the operation. To find out if an Ambulatory Center has been accredited or is licensed, call or write the Administrative Office.

Charges for Physician services are not payable under this section of the Plan. Refer to the benefit descriptions for Physician services on the following pages.

**SURGICAL SERVICES
IN A NON-PPO
AMBULATORY
CENTER**

**NOTE: IT IS STRONGLY
RECOMMENDED THAT YOU
GET A COST ESTIMATE FROM
THE AMBULATORY CENTER
SINCE THE PLAN HAS LIMITS
ON ALLOWABLE CHARGES**

If an eligible individual undergoes a surgical procedure in a non-PPO Ambulatory Center that is accredited by the Accreditation Association for Ambulatory Health Care, Inc. or licensed by the state in which the center is located, the Plan will pay 60% of Allowable Charges made by the Ambulatory Center for services and supplies in connection with the surgery.

Limits on Allowable Charges: Allowable Charges are limited to \$5,000 per operative session.

Please note that the facility must meet the Plan’s definition of an Ambulatory Center (refer to page 108) in order for the preceding benefits to be paid. If the facility does not meet the Plan’s definition, benefits are payable at 60% up to a maximum payment equal to 10% of the amount payable to the surgeon for the operation. To find out if an Ambulatory Center has been accredited or is licensed, call or write the Administrative Office.

Charges for Physician services are not payable under this section of the Plan. Refer to the benefit descriptions for Physician services on the following pages.

Extended Care Facility Services

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 an Extended Care Facility for additional treatment or rehabilitation (this does not include Custodial Care), the Plan will pay 100% of the Extended Care Facility's Allowable Charges for a semi-private room for the first 30 days and 90% of Allowable Charges thereafter during any one period of confinement. Allowable Charges for other Medically Necessary services and supplies during in-patient confinement will be paid at 90%.

Extended Care Facility Benefits are payable for a maximum of 180 days for any one 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 days.

Surgical Services

NOTE: Voluntary Pre-authorization is recommended if the cost is expected to exceed \$1,500. Refer to "Pre-Authorization" earlier in this Chapter.

Medically Necessary maxillofacial surgical procedures are covered when performed by a Physician (M.D.) or qualified oral and/or maxillofacial surgeon.

Has Surgery Been Recommended?

If so, we urge you to consider obtaining a second opinion on the need for surgery from a Board-certified specialist. There may be other methods of treatment that are more appropriate for you. Refer to the Second Surgical Opinion Benefits described on page 39.

Also, here are some ways you can make your health dollars count and save money:

- Use a PPO Physician. The Plan will pay more of the bill if a PPO Physician renders services than it would if services are rendered by a non-PPO Physician. Refer to "How Does the Plan Work?" at the beginning of this Chapter for information on the PPO.
- If hospitalization is necessary, ask your Physician if the tests required for Hospital admission can be performed on an out-patient basis prior to admission.

SURGERY PERFORMED BY A PPO PROVIDER

The Plan will pay 90% of the Allowable Charges made by a PPO provider for performing a surgical procedure.

If surgery is performed in a PPO facility other than a Hospital or Ambulatory Center and a separate charge is made for supplies furnished in connection with the operation, the Plan will pay 90% of the Allowable Charges for the supplies.

SURGERY PERFORMED BY A NON-PPO PROVIDER

The Plan will pay 60% of the Allowable Charges made by a non-PPO provider for performing a surgical procedure. If surgery is performed in a non-PPO facility other than a Hospital or Ambulatory Center and a separate charge is made for supplies furnished in connection with the operation, the Plan will pay 60% of the Allowable Charges for the supplies.

*If surgery is performed in the emergency room of a **Hospital**, the Plan will pay 90% of the Physician's Allowable Charges even if the Physician is not a PPO provider. Please note however, that the difference between the billed charges and the Allowable Charge is still the member's responsibility.*

ASSISTANT SURGEONS When the services of an assistant surgeon are deemed Medically Necessary by the Trust, the Plan will pay Allowable Charges made by an assistant surgeon as follows:

- 90% if performed by a PPO provider
- 60% if performed by a non-PPO provider

The maximum payment for the services of an assistant surgeon is as follows:

- when performed by a PPO provider: 20% of the Allowable Charge for a primary surgeon who is a PPO provider
- when rendered by a non-PPO provider: 20% of the Allowable Charge for a primary surgeon who is a non-PPO provider

PHYSICIANS ASSISTANTS

The maximum payment for the services of a physicians assistant is as follows:

- when performed by a PPO or non-PPO provider: 10% of the allowable charge for a primary surgeon

STAND-BY SURGEONS When a stand-by surgeon is deemed Medically Necessary by the Trust, the Plan will pay the Allowable Charges made by a stand-by surgeon as follows (subject to the “Limit on Allowable Charges” referenced below):

- 90% if the stand-by surgeon is a PPO provider
- 60% if the stand-by surgeon is a non-PPO provider

Benefits will be paid for a stand-by surgeon only if the stand-by surgeon would not normally be in the Hospital at the time of the operation.

Limit on Allowable Charges: Allowable Charges are limited to \$500 per operative session for stand-by services of a non-PPO provider.

SECOND SURGICAL OPINION
THE DEDUCTIBLE IS WAIVED

If an Eligible Individual consults a “qualified physician” for a second surgical opinion on the need for a proposed surgical procedure that is covered by the Plan, the Plan will pay 100% of the qualified physician’s Allowable Charge for the consultation, including charges for x-rays and laboratory tests ordered by the qualified physician in connection with the rendering of the second opinion, up to a maximum payment of \$150.

In the event the second surgical opinion does not confirm the need for surgery and the Eligible Individual consults another “qualified physician” for a third opinion, the Plan will pay 100% of the qualified physician’s Allowable Charge for the consultation, including charges for x-rays and laboratory tests ordered by the qualified physician in connection with the rendering of the third opinion, up to a maximum payment of \$150.

A “qualified physician” means a Physician who is Board-certified in the field of medical specialization concerned with the condition involved. In order for benefits to be paid, the qualified physician must not perform the proposed surgery or otherwise have a financial interest in the outcome of his/her recommendation. You can call the County Medical Association for a list of specialists from which to choose.

Frequently Asked Questions

Q Why obtain a second surgical opinion?

A When confronted with the question of whether or not to have surgery, it is important for you to know as much as possible about your condition, alternative treatment possibilities and the surgical risks involved.

Q What will my physician say?

A Getting a second opinion is considered a standard practice today. Most Physicians want their patients to be as informed as possible about their conditions.

Physician Visits—Office, Hospital, Home or Other Visits

Need to Visit a Physician?

Consider using a PPO Physician. Benefits are higher when you use a PPO Physician, and these Physicians have agreed to provide services at specified fees that may lower your out-of-pocket costs.

If an Eligible Individual receives non-surgical, Medically Necessary treatment from a Physician, the Plan will pay Allowable Charges as follows:

- 90% if services are rendered by a PPO provider
- 60% if services are rendered by a non-PPO provider unless the services are for Emergency treatment rendered in the emergency room of the Hospital in which case benefits are payable at 90% of Allowable Charges; **see Chapter 10 for the Plan’s definition of Emergency.**

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 will be 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.

This benefit covers routine Hospital visits by Physicians for newborn care. It does NOT include Physician visits in connection with Substance Abuse, chiropractic treatment, physical therapy or Psychiatric Care—separate benefits are provided for those conditions.

Routine Physical Examinations *THE DEDUCTIBLE IS WAIVED*

FOR YOU AND YOUR SPOUSE

The Plan will pay 100% of Allowable Charges for a Physician’s professional services and x-ray and laboratory tests you or your spouse undergo in connection with a routine physical examination, including mammograms and Pap smears, up to the following maximum payments:

\$500 per person per calendar year for the Physician’s professional services, x-ray and laboratory tests.

FOR YOUR CHILDREN

Benefits are provided for routine physical examinations of Dependent children under 14 years of age. A total of 16 examinations are covered based on the following schedule:

| Age of Child | Maximum Number of Covered Exams |
|------------------------------|---------------------------------|
| Under 6 months | 3 |
| From 6 months up to 2 years | 5 |
| From 2 years up to 6 years | 4 |
| From 6 years up to 10 years | 2 |
| From 10 years up to 14 years | 2 |

Physician charges are payable at 100% of Allowable Charges using a PPO provider. Charges for laboratory tests are payable at 100% of Allowable Charges. A combined maximum payment of \$30 for each examination including laboratory tests will be allowed when the Physician is not a PPO provider.

Refer to “Physician Visits” immediately above regarding benefits for the initial routine evaluation of a newborn by a Physician.

Please note that Dependent children over 14 years of age are not covered for routine physical examinations including laboratory tests in connection with a routine physical examination.

Chiropractic Services

(Not included in the Plan’s stop-loss limit feature)

If an Eligible Individual undergoes chiropractic treatment performed by a Physician or licensed chiropractor, the Plan will pay 100% of Allowable Charges, up to a maximum payment of \$10 for each visit.

Not more than one visit is covered per day, and not more than 24 visits are covered per person per calendar year.

Psychiatric Care

(Not included in the Plan's stop-loss limit feature)

If an Eligible Individual receives Psychiatric Care, the Plan will pay benefits as described below for the services listed below when Medically Necessary. Psychiatric Care benefits do not include coverage for psychometric testing or biofeedback services. Refer to "Other Covered Services and Supplies" later in this section for coverage of those items.

FULL-TIME IN-PATIENT
HOSPITAL CONFINEMENT
(PPO OR NON-PPO
HOSPITAL)

NOTE: Pre-authorization is recommended for this benefit. Refer to "Pre-Authorization" earlier in this chapter.

The Plan will pay 50% of Allowable Charges for Hospital room and board and other services and supplies furnished and billed by a Hospital for up to 31 days per calendar year for an Eligible Individual who is a full-time registered bed patient (the 31 days are a combined maximum for full-time confinement and the partial confinement described immediately below).

No benefits will be paid for any day in which the patient is released from the Hospital on a temporary pass.

PARTIAL CONFINEMENT
TREATMENT PROGRAM
(PPO OR NON-PPO
FACILITY)

NOTE: Pre-authorization is REQUIRED for this benefit. Refer to "Pre-Authorization" earlier in this chapter.

A "partial confinement treatment program" is a planned program of psychiatric services for the treatment of mental or nervous disorders which are subject to favorable modification given by a Psychiatric Treatment Facility on either a

- day care basis without a room charge being made for an in-patient stay (the program must be available for at least 6 hours during the day and at least 5 days a week) or
- night care basis with a room charge being made (the program must be available for at least 8 hours a night and at least 5 days a week).

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.

The Plan will pay 50% of the Allowable Charges for up to 31 days per calendar year for the services and supplies listed below when they are received in a Psychiatric Treatment Facility under a "partial confinement treatment program" as defined above (the 31 days are a combined maximum for partial confinement and the full-time confinement described above).

The treatment program must begin within 14 days following discharge from full-time in-patient Hospital confinement for which Plan benefits for Psychiatric care were paid.

Covered Services and Supplies

- Services of a Physician (either an employee of the treatment facility or a Physician who has a formal agreement with the facility to provide professional services)
- Services of a Registered Nurse who has special psychiatric training, a licensed psychologist, a licensed clinical social worker or a licensed master social worker if ordered by and under the direction of a staff Physician
- Other institutional services and supplies furnished by the Psychiatric Treatment Facility as part of the partial confinement treatment program, including facility charges

The maximum Allowable Charge for each session with respect to the facility is the most common semi-private room rate in the geographical area in which services are rendered. A treatment session begins when the patient enters a Psychiatric Treatment Facility and ends when the patient leaves the facility upon completion of one-day care or one night care of treatment.

OUT-PATIENT HOSPITAL
(PPO OR NON-PPO
HOSPITAL)

The Plan will pay 80% of Allowable Charges for Hospital pre-admission testing only.
There is no other coverage for out-patient psychiatric facilities.

IN-PATIENT PROFESSIONAL
CARE (PPO OR NON-PPO
PROVIDER)

The Plan will pay 80% of Allowable Charges for professional services of a Physician which are rendered to an Eligible Individual during in-patient Hospital confinement for which in-patient Hospital benefits as described above are payable. Only the services of a Physician are covered for in-patient professional care.

Not more than one visit by a Physician is allowable per day.

OUT-PATIENT
PROFESSIONAL CARE (PPO
OR NON-PPO PROVIDER)

The Plan will pay 80% of Allowable Charges for professional services of an eligible provider (defined below) which are rendered on an out-patient basis, up to a maximum payment of \$60 per visit.

An eligible provider under this benefit is a Physician, or when the patient is referred by a Physician, a licensed psychologist, licensed clinical social worker or licensed master social worker. A licensed Marriage, Family and Child Counselor is NOT an eligible provider under the Plan.

A maximum of 60 visits per calendar year are covered. No more than one visit per day will be allowed.

Exclusions

In addition to the items listed under “What Is Not Covered?” later in this Chapter, Psychiatric Care benefits will not be paid for the following:

- marriage counseling
- vocational rehabilitation programs
- therapeutic treatment of Substance Abuse (see benefits for Substance Abuse treatment below)
- full-time inpatient Hospital confinement for any day in which the eligible individual is released from the Hospital on a temporary pass
- services or supplies provided by a facility not specifically described in this benefit section

Substance Abuse Treatment

(Not included in the Plan’s stop-loss limit feature)

If an Eligible Individual undergoes therapeutic treatment of Substance Abuse, the Plan will pay 80% of Allowable Charges for the following services and supplies, up to a lifetime benefit of \$5,000 per person, whether or not there has been an interruption in coverage or change in eligibility status:

- professional services of a Physician, licensed psychologist, licensed clinical or master social worker, or a State-certified alcoholic counselor
- Medically Necessary services and supplies furnished and billed by a Hospital or Substance Abuse Treatment Center

Exclusions

In addition to the items listed under “What Is Not Covered?” later in this Chapter, Substance Abuse treatment benefits will not be paid for:

- nicotine or caffeine addiction
- marriage counseling
- vocational rehabilitation programs

Physical Therapy (Out-patient)

NOTE: Pre-authorization is recommended for this benefit and for referral to a PPO Provider under direct contract with the Trust. Refer to “Pre-Authorization” earlier in this Chapter.

The Plan will pay 90% of Allowable Charges for the services of a registered physical therapist or registered or State-licensed occupational therapist for short-term therapy if such provider is a PPO provider. If services are provided by a non-PPO provider then benefits are reduced to 60% of Allowable Charges and the “Limit on Allowable Charges” referenced below applies.

Not more than one session (visit) is allowable per day and not more than 20 sessions (visits) are allowable during a calendar year (PPO and non-PPO combined).

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 ordered by a Physician under an individual treatment plan and must be certified by the Physician as Medically Necessary for the improvement of the patient’s condition through short-term care.

Limit on Allowable Charges: The maximum Allowable Charge for a total of one hour of physical therapy is \$60 when services are rendered by a non-PPO provider.

Speech Therapy (Out-patient)

NOTE: Pre-authorization is recommended for this benefit. Refer to “Pre-Authorization” earlier in this Chapter.

If an Eligible Individual undergoes out-patient speech therapy, the Plan will pay 90% of the Allowable Charges made by a PPO provider,. If services are provided by a non-PPO provider then benefits are reduced to 60% of Allowable Charges and a maximum payment of \$40 for each therapy session (visit) applies.

In order for benefits to be payable, the PPO or non-PPO provider must be a Physician, or when referred by a Physician, a licensed speech pathologist or a licensed speech therapist.

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, and not more than 130 visits are covered during a person’s lifetime (PPO and non-PPO combined), whether or not there has been an interruption in coverage or change in eligibility status.

Nursing and Home Health Care Services

NOTE: Pre-authorization is recommended for this benefit. Refer to “Pre-Authorization” earlier in this Chapter.

If an Eligible Individual receives services from a Registered Nurse which are Medically Necessary, the Plan will pay 90% of the Allowable Charges made for such services if the Registered Nurse is a PPO provider.

The Plan will pay 90% of the Allowable Charges made by a Home Health Care Agency for skilled medical services, including those of a licensed vocational nurse which are Medically Necessary if the Home Health Care Agency is a PPO provider.

If services are provided by a non-PPO provider then benefits are reduced to 60% of Allowable Charges and the “Limits on Allowable Charges” referenced below applies.

When a Registered Nurse or licensed vocational nurse provides services, benefits will be paid only for those services rendered by the nurse which require the skill and training of the nurse.

These benefits do not cover services of a nurse-aid, Custodial Care or housekeeping services.

Limits on Allowable Charges: The maximum Allowable Charge for a Registered Nurse is \$120 per visit if the Registered Nurse is not a PPO provider. The maximum Allowable Charge for a licensed vocational nurse is \$60 per visit if the licensed vocational nurse is not a PPO provider.

Hospice Care Benefits

NOTE: Pre-authorization is REQUIRED for these benefits. Refer to “Pre-Authorization” earlier in this Chapter.

If an Eligible Individual’s medical condition is terminal and is likely to result in death within a 3-month period and such Eligible Individual receives Custodial Care from a hospice program certified by Medicare, the Plan will pay 100% of the Allowable Charges for Custodial Care, up to a lifetime benefit of \$7,500 for the Eligible Individual.

Exclusions

In addition to the items listed under “What Is Not Covered?” later in this Chapter, hospice care benefits will not be paid with respect to a hospice program that is not certified by Medicare or care that has not been pre-authorized by the Trust.

Maternity

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.

If a Certified Nurse-Midwife renders the services, the Plan will pay 60% of the Allowable Charges made by the Certified Nurse-Midwife. The services performed must be within the scope of the Certified Nurse-Midwife’s license. The amount of Allowable Charges is based on the amount allowable for a normal delivery.

Maternity benefits are not available for a dependent child.

Organ Transplants

The Plan will pay for Allowable Charges in connection with the following organ transplants on the same basis as any other illness:

- kidney transplants,
- liver transplants (in cases of congenital biliary atresia only),
- transplants of cornea, skin, bone and tendons
- transplants of bone marrow if the diagnosis is non-intentionally induced severe aplastic anemia or acute leukemia (bone marrow transplants for other diagnoses are not covered),
- transplants of artificial organ parts-limited only to joint replacement for functional reasons, skin, heart valves, grafts and patches (vascular), pacemaker, metal plates and eye lens

Allowable Charges incurred by an organ donor for a covered transplant will also be payable on the same basis as any other illness but benefits will only be payable if the organ recipient is an Eligible Individual under this Plan.

Other Covered Services and Supplies

The Plan will pay 90% of Allowable Charges for the items listed below. If a non-PPO provider provides the service or supply then benefits are reduced to 60% of Allowable Charges

Artificial limbs or eyes (excluding their replacement), casts, splints, trusses or braces

- Durable medical equipment (DME), not to exceed a reasonable purchase price (*see “Pre-Authorization” earlier in this Chapter regarding recommended pre-authorization for this benefit and referral to a PPO provider under direct contract with the Plan*). DME is equipment which
 - can withstand repeated use,
 - is primarily and customarily used to serve a medical purpose,
 - is generally not useful to a person in the absence of injury or sickness, and

- is appropriate for use in the home.

Purchase of DME and the cost of maintenance agreements are covered only when the Plan determines that it is cost-effective for the Plan. The amount of benefits payable for the purchase of DME will be reduced by any benefits paid by the Plan for the rental of such equipment.

Coverage for the rental or purchase of DME is limited to the standard item of the equipment, as determined by the Plan, solely in its sole and absolute discretion. Costs associated with the customization or personalization of DME or, comfort, convenience or luxury equipment are not covered by the Plan.

- Blood, blood plasma and blood processing fees
- Anesthetics and the services of a Physician or licensed anesthetist for administration of anesthetics
- Diagnostic tests and services, including x-ray and laboratory (*see “Pre-Authorization” earlier in this Chapter regarding recommended pre-authorization for CAT scans and MRI’s and referral to PPO providers under direct contract with the Trust*).
- Services of a laboratory technician
- Use of x-ray, radium and other radioactive substances
- Oxygen and the rental of equipment for administration of oxygen
- Professional ambulance service to and from the nearest Hospital where care and treatment of the injury or sickness can be given (maximum Allowable Charges are a base fee of \$700 and \$15 per mile for a ground ambulance and a base fee of \$5,000 and \$70 per mile for an air ambulance)
- Hearing aids, including fitting and repairs, not to exceed a maximum payment of \$300 in a three year period
- Psychometric testing, up to a maximum of 8 hours per disability, and biofeedback services, up to a maximum of four visits per disability
- Services of a paramedic
- Services of a licensed perfusionist
- Immunizations

What Is Not Covered?

In addition to the General Limitations and Exclusions listed in Chapter 10 and any limitations or exclusions contained in the benefit descriptions under “What is Covered?,” Fee-for-Service Medical Option benefits are not provided for expenses in connection with the following:

- medical examinations, services and supplies determined by the Trust to be not Medically Necessary, except
 - as provided under the Plan’s routine physical examination benefit,
 - routine Hospital care of a newborn Dependent child during Hospital confinement,
 - immunizations, and
 - as provided under the Plan’s hospice care benefit
- eye refraction, eyeglasses or contact lenses, or the fitting of eyeglasses or contact lenses, (*these items may be covered under the Plan’s Spectera Vision Care coverage-refer to Chapter 4*)
- replacement of a lost hearing aid, except when benefits would otherwise be payable
- cosmetic surgery or treatment and any complications arising from such surgery or treatment, except
 - operations necessary to repair disfigurement due to an accident
 - operations necessary to repair a congenital anomaly in a Dependent child, or
 - reconstructive surgery following a mastectomy-reconstruction of the breast on which surgery was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance
 - any operation or treatment in connection with the fitting or wearing of dentures or for treatment of the teeth or gums, except Allowable Charges in connection with the following treatment when rendered by a Physician or Dentist:

- treatment of tumors or lesions,
- treatment of accidental injury to sound natural teeth (including their replacement) and fractures
- services and supplies covered under the Plan's Hospital and anesthesia benefits for treatment that is required to be performed in a Hospital as determined by the Trust (In order for such services to be covered, pre-authorization is REQUIRED-see "Pre-Authorization" earlier in this Chapter-and the anesthesia services must be rendered by a Physician)

For information on dental care benefits, refer to the Plan's separate dental coverage options. Information on the Fee-for-Service Dental option can be found in Chapter 5.

- conditions of pregnancy of a dependent child or former Dependent child who is a COBRA participant
- vision therapy (orthoptics), unless it is in lieu of a surgical procedure
- the administration of local infiltration anesthetics or the administration of anesthetics by a Physician performing or assisting in performing a surgical procedure
- marriage, family or child counseling
- long-term maintenance therapy or group exercise programs
- chiropractic treatment, except as provided under the Plan's chiropractic benefits
- Psychiatric Care, except as provided under the Plan's Psychiatric Care benefits
- treatment of Substance Abuse, except as provided under the Plan's Substance Abuse treatment benefits
- acupuncture treatment
- 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.)
- chelation therapy, except in cases of lead poisoning
- genetic testing or counseling
- eating disorders

HOW TO FILE A CLAIM FOR BENEFITS UNDER THE FEE-FOR-SERVICE MEDICAL OPTION

NOTE: The discussion below applies to "post-service claims"-claims you submit after you have received a service. The following are also considered claims: requests for required pre-authorizations from the Trust's Administrative Office and decisions made by the Administrative Office regarding treatment in progress. See "Pre-Authorization" earlier in this Chapter and "Claims Review Procedures" in Chapter 10 for more information.

You can obtain claim forms from the Administrative Office by calling (213) 385-0551 or toll-free (800) 252-9255. Be sure to specify that you need a claim for medical benefits, as the Plan has separate claim forms for medical, dental and vision expenses. You can also get claim forms at your Union Office.

Claims for Hospital Services

If you are admitted to a Hospital, all you need to do is show your Southwest Carpenters Health and Welfare Trust identification card with the PPO logo on it (Blue Cross Prudent Buyer Plan for California residents, CCN for Arizona residents and Beech Street for those who reside in all other areas) and provide the member's Social Security Number to the admitting office and ask that the claim be sent to the following address:

In California – Blue Cross Prudent Buyer Plan, P.O. Box 60007, Los Angeles, CA 90060-0007

In all other areas – Southwest Carpenters Health and Welfare Trust, P.O. Box 17973, Los Angeles, CA 90017-0973

Claims for Services from PPO Providers Other Than Hospitals

If you use a PPO provider, show your Southwest Carpenters Trust identification card with the PPO logo on it (Blue Cross Prudent Buyer Plan for California residents, CCN for Arizona residents and Beech Street for those who reside in all other areas) and give the provider your Social Security number and a regular Plan claim form for medical benefits with the upper part filled out. The provider will then complete the claim for you and send it directly to the Administrative Office at:

Southwest Carpenters Health and Welfare Trust
P.O. Box 17973
Los Angeles, CA 90017-0973

Your provider may also use the universal HCFA claim form to submit claims to the Administrative Office.

See also “*Electronic Submission*” below.

Claims for Services from Non-PPO Providers Other Than Hospitals

If you use a non-PPO provider, you will usually need to file a claim yourself.

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 form must be filed for each patient.

Your completed claim should be mailed to the Administrative Office at the following address:

Southwest Carpenters Health and Welfare Trust
P.O. Box 17973
Los Angeles, California 90017-0973

Electronic Submissions

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
- Your Union Local number
- The date(s) of service
- The CPT-4 codes—the codes for Physician services and other health care services found in the *Current Procedural Terminology, Fourth Edition*, as maintained and distributed by the American Medical Association
- The ICD-9 codes—the diagnosis codes found in the *International Classification of Diseases, 9th Edition, 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 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.

Questions?

If you have any questions about submitting your claim, contact the Administrative Office.

For information on what to do if you disagree with the decision made in regard to your claim, see “Claims Review Procedures” in Chapter 10, “Other Important Plan Information.”

When a Separate Claim Form Is Required

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 within the past calendar-year period. Mail any further bills or statements for any medical or Hospital services covered by the Plan to the Administrative Office as soon as you receive them.

Chapter 3

FEE-FOR-SERVICE PRESCRIPTION DRUG BENEFIT SUMMARY

In this Chapter you'll find:

- What the benefits are
- Prescription quantity
- What's covered
- What's not covered
- Using a walk-in pharmacy
- Using the mail service
- Information on filing claims

The information in this Chapter applies to you only if you are an Eligible Individual enrolled in the Fee-for-Service Medical Option. If you are enrolled in one of the HMO options instead, see the separate booklet(s) issued by the HMO for information on your prescription drug benefits.

WHAT ARE THE BENEFITS?

If an Eligible Individual obtains covered prescription drugs at a participating pharmacy and in accordance with the procedures outlined on the following pages, the only cost to him will be the amounts outlined below. The Plan will pay the balance of the prescription cost directly to Pharmacy Benefit Manager (PBM).

A listing of participating pharmacies and the prescription drug Formulary is included in the materials sent to new members. If you need another copy of either one or both, you may call the Administrative Office. **When using a participating walk-in pharmacy, be sure to show your prescription ID card to the pharmacy to avoid having to pay the full cost of your prescriptions.**

IMPORTANT: The use of generic drugs will save you money.

Prescription Drugs Obtained at Participating Pharmacies

For prescriptions filled or refilled at a walk-in participating pharmacy (up to a 30-day supply):

| | |
|---|---|
| Generic drug | You pay \$10 per prescription or refill |
| Brand name Formulary drug when NO generic is available | You pay \$30 per prescription or refill |
| Brand name Formulary drug when generic is available | You pay \$30 per prescription or refill, plus the cost difference between the brand name and the generic |
| Non-Formulary drug | You pay \$50 per prescription or refill (if a generic is available but a brand name is dispensed you also pay the cost difference between brand name and the generic) |

For prescriptions filled or refilled through the mail order program (up to a 90-day supply):

| | |
|---|--|
| Generic drug | You pay \$20 per prescription or refill |
| Brand name Formulary drug when NO generic is available | You pay \$60 per prescription or refill |
| Brand name Formulary drug when generic is available | You pay \$60 per prescription or refill, plus the cost difference between the brand name and the generic |
| Non-Formulary drug | You pay \$100 per prescription or refill (if a generic is available but a brand name is dispensed you also pay the cost difference between brand name and the generic) |

If prescription drugs are not obtained at a participating pharmacy, the Eligible Individual must pay the pharmacy and file a claim for reimbursement. The Plan will pay 90% of what it would have paid had the prescription drug been obtained at a participating pharmacy less a member co-payment of \$50 per prescription or refill. You should be aware that your out-of-pocket costs will be significantly higher when you use a non-participating pharmacy since the Plan's 90% benefit is applied to the contracted price of the medication which is much less than the actual cost at non-participating pharmacies. Refer to the section on claims at the end of this Chapter for information on how to file a claim for reimbursement.

See the box under "What Is Covered?" below for information on payment of benefits for nutritional supplements.

PRESCRIPTION QUANTITY

Not more than a 30-day supply is allowable at walk-in pharmacies.

A 90-day maximum supply applies when prescriptions are dispensed by the mail order pharmacy. If less than a 90-day supply is prescribed and processed through the mail order pharmacy, your co-pay will be the same as the co-pay that applies when a 90-day supply is dispensed.

NOTE: Prescription drugs for treatment of male erectile dysfunction are limited to a quantity of 6 pills per month at walk-in pharmacies and 18 pills for a 90 day supply through mail order.

- benefits for any medication may be limited to less than a prescribed quantity (or excluded altogether) if the prescribed quantity (or the medication itself) is determined to be greater than the usual and customary recommendations of the PBM.

WHAT IS COVERED? (INCLUDING PRE-AUTHORIZATION RULES)

- All medications and contraceptive devices or injectables that may lawfully be dispensed only upon the written or telephoned prescription of a Physician or Dentist, except as noted under "What Is Not Covered"

See the definition of "Experimental" on page 110 of this booklet for information on the criteria to which new drugs will be subjected.

- In addition, the following items only, which do not require a prescription by law, if they are prescribed by a Physician or Dentist:

Insulin and diabetic supplies, including syringes and needles (disposable and non-disposable), test tablets, sticks and tape designed to test for sugar and acetone, and strips for measuring blood sugar

Nutritional supplements which, based on the diagnosis and medical condition, are required to sustain life or maintain a reasonable level of good health as determined by the Trust (these REQUIRE pre-authorization-see Pre-authorization box on the next page)

- The following drugs also require pre-authorization before coverage can begin:

Growth hormone

Interferon

Oxycontin

Oxycodone

Dilaudid or its generic equivalent Hydromorphone

Actiq

Other controlled substances

Your network pharmacist will obtain pre-authorization of your growth hormones for you when you present your prescription for dispensing. If you use the Mail Service pharmacy, that pharmacy will obtain pre-authorization before dispensing the medication. If your prescription is for any of the other drugs listed above you must obtain pre-authorization from the Administrative Office – see Pre-authorization box on next page.

IMPORTANT: The use of generic drugs will save you money. The generic name of a drug is simply its chemical name. A brand name is a trade name under which the drug is advertised. Please ask your Physician or Dentist to prescribe generic drugs, when possible. In general, a generic drug will be dispensed if available unless you or the prescribing Physician or Dentist indicate that no substitution be made. In such a case, your cost will be the brand name co-pay plus the difference in cost between the drug actually dispensed and its generic equivalent.

Pre-Authorization

Written pre-authorization by the Administrative Office is required for nutritional supplements, Interferon, Oxycontin, Oxycodone, Actiq, Dilaudid, or its generic equivalent Hydromorphone and other controlled substances. These items must be pre-authorized before you have your prescriptions dispensed in order for benefits to be paid. There are two ways you can request pre-authorization:

- By telephoning: You or your physician may telephone (213) 385-0551 or toll-free (800) 252-9255.
- By submitting a request in writing: You or the prescribing Physician or Dentist can submit a request for pre-authorization in writing. The written request must include the member's (Carpenter's) Social Security number, the patient's name, the prescribing Physician's or Dentist's name and telephone number and the strength, dosage and quantity of the proposed medication and the patient's diagnosis. Mail the written request for pre-authorization to the Administrative Office. You can also deliver it to the Administrative Office in person. Any supporting documents should accompany the request.

A medical consultant will review the information submitted and make a determination on whether or not the prescribed items meet the Plan's benefit requirements. The determination will ordinarily be sent to you and your physician within 15 days from the date the request for pre-authorization is received by the Administrative Office. For more information about the time frames for responding to requests for required pre-authorizations and for information on how you can appeal if you disagree with the decision made, see the entries for "pre-service claims" in "Claims Review Procedures" in Chapter 10.

WHAT IS NOT COVERED?

In addition to the General Limitations and Exclusions listed in Chapter 10, Prescription Drug Plan benefits are not payable for the following:

- drugs that are paid for in part or in whole under another group health plan (this Plan does not reimburse an Eligible Individual's co-payments or co-insurance that may be required under another group health plan)
- prescriptions obtained at a Hospital or Extended Care Facility
- medications that may be procured without a Physician's or Dentist's prescription, except as noted under "What Is Covered?" above
- gamma globulin, immunization agents, blood and blood plasma
- Gerovital and Geriatrium
- anti-obesity agents and fertility agents
- drugs dispensed directly by a Physician or Dentist
- appliances, prosthetics, devices, bandages, heat lamps, braces, splints, and all non-drug items except diabetic supplies and contraceptive devices as noted under "What Is Covered?"
- vitamins (except prenatal vitamins that require a Physician's prescription in order to be dispensed), cosmetics, dietary supplements (except nutritional supplements as noted under "What Is Covered?"), health and beauty aids
- injectable forms of drugs for treatment of erectile dysfunction
- benefits for any medication may be limited to less than a prescribed quantity (or excluded altogether) if the prescribed quantity (or the medication itself) is determined to be greater than the usual and customary recommendations of the PBM.

Prescription Tips

- Please remember that a prescription order must be legible and must indicate the drug's name and strength, the quantity to dispense, the exact daily dosage and the Physician's name, phone number and DEA number.
- If you are using a participating walk-in pharmacy, please remember to show the pharmacy your prescription ID card.
- If you are taking a medication that is not on the prescription Formulary, show your physician a prescription Formulary list and ask if your medication can be changed to an equivalent medication on the list.
- To obtain a Formulary list, contact the Administrative Office.

HOW TO FILL PRESCRIPTIONS USING THE WALK-IN SERVICE

IMPORTANT: If you need to take medication on a regular ongoing basis, we urge you to use the **mail service** pharmacy. It will save you money.

If you need to start on your maintenance medication right away, have your Physician complete two prescriptions: one for a 30-day supply and one for the remaining supply authorized by your Physician. Fill the 30-day supply prescription at a participating pharmacy and submit the other prescription to the mail service pharmacy.

Participating Pharmacies

To have a prescription filled at a participating pharmacy, follow these simple steps:

- Take your prescription to any of the walk-in participating pharmacies. If you need the location of network pharmacies, simply call the Administrative Office.
- Present your prescription and your prescription I.D. card to your participating pharmacist.
- Once eligibility has been determined and any required pre-authorization obtained, your prescription(s) will be filled. Upon receiving the prescription(s), you will be asked for the applicable co-payment amount for each prescription and to sign a form which represents the billing to the Trust. **DO NOT SIGN THIS FORM BEFORE YOU RECEIVE YOUR PRESCRIPTION(S).** You may be asked to sign more than one form if you have more than two prescriptions for yourself or if prescriptions are filled for more than one family member.

Refills

You may, of course, request a refill from the pharmacy by phone for pick-up at a later time. Identify yourself as eligible for prescription drug benefits under this Plan when calling, have your prescription ID card in front of you and be prepared to give the pharmacist your Social Security number. As long as you remain an Eligible Individual, and provided your Physician or Dentist authorizes refills, your prescription will be refilled.

Non-Participating Pharmacies

If you have a prescription filled or refilled at a non-participating pharmacy, you will need to pay the full amount for the prescription at the time of purchase, then request reimbursement of the applicable amount. Please be aware that your out-of-pocket costs will be much higher when you use a non-participating pharmacy. Prescription reimbursement claim forms can be obtained from the Administrative Office.

HOW TO FILL PRESCRIPTIONS USING THE MAIL ORDER SERVICE

The mail service plan is designed for those of you who take prescription medication on a regular, ongoing basis, such as Inderal for high blood pressure. This program is not intended to cover prescription drugs needed immediately and/or on a short-term basis - less than 30 days. You should obtain those types of prescription drugs from a local participating pharmacy.

- Complete the Prescription Mail Order Form by following the directions on that form. –
- Mail your original prescription(s) – prescriptions must be written on a Physician's prescription form with the Physician's original signature, the completed Prescription Mail Order Form, and your applicable co-payment in the pre-addressed envelope provided.

Mail Service Payment Options

For your convenience, you can bill your co-payment to your credit card (VISA, MasterCard, Discover, American Express or debit cards with a MasterCard or Visa logo). Fill out the "Payment Information" section before sending your Prescription Mail Order Form. Please note that on-line orders (through the website) require payment by credit or debit card.

If you are ordering by mail, you may also pay by check.

Delivery

Your medications will be delivered directly to your home by First Class U.S. Mail or a national mail courier service like FedEx or UPS in unmarked, tamper-proof packages. Items requiring refrigeration are sent in insulated packages. Normally, you can expect to receive your medication within 10 business days from the day the mail service pharmacy receives your order.

PLEASE NOTE: A complete street address (no P.O. boxes) is required for controlled medications, and an adult signature is required upon receipt.

Mail Service Refill Limitations

Prescriptions may be refilled three times (provided your Physician or Dentist has authorized three refills). Please note that Federal law limits the dispensed quantities of certain controlled substances.

Remember to order your prescription refill at least 3 weeks before your current supply runs out. Reordering information is enclosed with each shipment.

Refills by Phone

Call the number on the medicine bottle. Before you place your call, have your I.D. number in hand from statement. Check the label on each prescription and have available the patient's name, the prescription number and the drug name, strength and quantity.

Refills by Mail

In each order you receive from the mail order pharmacy you will find a Refill Request. The Refill Request includes details on how to obtain refills.

Refills Online

Go to the website provided in your prescription packet, enter your user name and password, which is set up on-line, then connect to Refill links.

HOW TO FILE A CLAIM FOR FEE-FOR-SERVICE PRESCRIPTION DRUG BENEFITS

NOTE: The discussion below applies to "post-service claims"-claims you submit after you have had a prescription filled or refilled. Requests for required pre-authorization from the Trust's Administrative Office are also considered claims. See the box "Pre-authorization" earlier in this Chapter and "Claims Review Procedures" in Chapter 10 for more information.

Participating Pharmacies

There is no need to file a claim for reimbursement if you obtain your drugs at a participating pharmacy using your I.D. card. See "How to Fill Prescriptions Using the Walk-In Service" and "How to Fill Prescriptions Using the Mail Service" earlier in this Chapter for information on how to use these services.

Non-Participating Pharmacies

If you do not use a participating pharmacy for your prescription drugs, use the following procedures to file a claim for reimbursement:

- Obtain a Prescription Claim form from the Administrative Office.
- Fill out the form completely.
- Check the claim form to be certain that all applicable portions of the form are completed and that you are submitting all itemized bills (cash register receipts, canceled checks or handwritten receipts are NOT acceptable). 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.
- Mail the completed form along with all itemized receipts to the address provided on your claim form.

Deadline for 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.

Questions?

If you have any questions about submitting your claim, contact the Administrative Office.

For information on what to do if you disagree with the decision made in regard to your claim, see “Claims Review Procedures” in Chapter 10, “Other Important Plan Information.”

Frequently Asked Questions

Q What is a formulary?

A A formulary is a list of preferred medications that includes drugs that are safe, clinically effective, and economical. The prescription formulary was developed by a committee of pharmacists and physicians. This committee meets regularly to discuss new drugs and trends in therapy. Medications included in the formulary have been demonstrated to be clinically effective and are also cost-effective to help manage prescription drug costs while continuing to maintain the quality of care. The Plan has adopted the Pharmacy Benefit Manager’s (PBM) formulary as the Plan’s formulary under its Fee-For-Service Prescription Drug coverage.

Q What if I forgot to bring my ID card to the participating pharmacy?

A The pharmacy may require you to pay the full cost for your prescriptions. If that is the case, ask the pharmacy if you can bring in your prescription ID card at a later date so you can get a refund. Most pharmacies allow you to do that but be aware that there are time limits that vary by pharmacy. So, go back to the pharmacy with your prescription ID card as soon as you can. If you have previously had your prescriptions dispensed at the participating pharmacy and the pharmacy has your information on file, they may (at the pharmacy’s discretion) only require the member’s (Carpenter’s) Social Security number to process your prescription.

Q Can I get an early refill of my prescriptions if I am going out of town?

A No, this is not permitted since the pharmacy network includes several national chains that you can use to get your prescriptions filled or refilled.

Chapter 4

SPECTERA VISION CARE COVERAGE SUMMARY

In this Chapter you'll find:

- What the benefits are
- When benefits are available
- How to use the program
- What is not covered
- Information on filing claims

The information in this Chapter applies to you only if you are an Eligible Individual enrolled in the Fee-for-Service Medical Option or an HMO option other than Kaiser. If you are enrolled in Kaiser instead, see the separate booklet(s) issued by Kaiser for information on your vision care benefits

WHAT ARE THE BENEFITS?

The Vision Care coverage will pay 100% of Allowable Charges after the applicable co-payment when an Eligible Individual receives covered services and supplies from a Spectera network provider when benefits are available to you (see “WHEN ARE BENEFITS AVAILABLE?” on the next page). **The co-payments are \$10 for an eye examination and \$20 for lenses only or lenses and a frame.** Covered services and supplies include the following:

- an eye examination for glasses or contact lenses
- prescription eyeglass lenses, including single vision, bifocal (D28 or equal) or trifocal (7 x 28 or equal), OR, in place of eyeglasses, daily wear soft spherical contact lenses
- prescription sunglasses in place of standard eyeglasses or contact lenses
- prescription safety or computer glasses in place of standard eyeglasses or contact lenses
- frame (you may select any one from among 700 to 1,000 different frames)
- scratch coating of lenses
- certain oversized lenses
- polycarbonate lenses for adults and children

If services are obtained from a provider who is NOT in the Spectera network, Spectera will pay benefits as shown in the following chart when benefits are available:

| Benefit Schedule for Services From Providers NOT in the Spectera Network | |
|--|--|
| Deductible | None |
| Type of Service or Supply | Maximum Allowance |
| Examination | \$40 |
| Lenses, each pair: | |
| • Single vision | \$40 |
| • Bifocals | \$60 |
| • Trifocals | \$80 |
| • Lenticular | \$125 |
| Frames | \$65 |
| Contact lenses, each pair: | |
| • Necessary (following surgery) | \$210 |
| • Cosmetic | \$125 (instead of benefits for eyeglasses) |

If only one lens is needed, the allowance will be one-half of the stated pair allowance.

If You Have Coverage Elsewhere

If you or your dependents have vision 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 “Coordination of Benefits and Reimbursement Obligation” in Chapter 10 for more information.

WHEN ARE BENEFITS AVAILABLE?

Benefits for an examination and pair of lenses (or, in lieu of eyeglasses, contact lenses) are available to an Eligible Individual once every 12 months and benefits for a frame are available once every 24 months.

HOW TO USE THE PROGRAM

When you need vision care services, call Spectera- to schedule an appointment at an office convenient to you.

Customer Service (800) 638-3120

Provider Locator (800) 839-3242

If you obtain services from a provider who is not a Spectera- 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?

In addition to the General Limitations and Exclusions listed in Chapter 10, Vision Care Plan benefits are not payable for the following:

- services or supplies payable under any other benefits provided by the Plan
- orthoptics or vision training (if you are enrolled in the Fee-For-Service Medical option, that option may cover orthoptics or vision therapy if it is in lieu of a surgical procedure), subnormal vision aids or non-prescription lenses
- reading rate and comprehension studies
- replacement of lost, stolen or broken lenses or frames for which payment was previously made under this benefit, except at the normal intervals when services and supplies are otherwise available
- surgical correction of refractive errors including but not limited to Lasik or similar procedures (if you are enrolled in the Fee-For-Service Medical Option, that Option may cover such surgeries on a limited basis when the patient’s myopia cannot be corrected to 20/40 or better by eyeglasses or contact lenses)

HOW TO FILE A CLAIM FOR BENEFITS UNDER THE SPECTERA VISION CARE COVERAGE

Spectera Network Providers

There is no need to file a claim if you obtain services and supplies from a Spectera- network provider. Refer to “How to Use the Program” earlier in this chapter for information on how to schedule an appointment.

Providers Not in the Spectera Network

If you use a non-network provider for covered vision care 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 provider. The itemized bill must include the patient’s name, 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.

- Mail the itemized bill to:

Spectera Claims Dept.
P.O. Box 26618
Baltimore, MD 21244-2644

Deadline for 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.

Questions?

If you have any questions about submitting your claim, contact the Administrative Office.

For information on what to do if you disagree with the decision made in regard to your claim, see “Claims Review Procedures” in Chapter 10, “Other Important Plan Information.”

Frequently Asked Questions

- Q** Are there any vision benefits after I cease to be an Eligible Individual?
- A** In the event an Eligible Individual loses eligibility under the Plan, benefits will be payable for the completion of services actually in progress at the time the patient was an Eligible Individual, but not beyond 90 days following loss of eligibility.

Chapter 5

FEE-FOR-SERVICE DENTAL OPTION SUMMARY

In this Chapter you'll find:

- What the benefits are
- What is covered
- What is not covered
- Information on filing claims
- Schedule of Dental Allowances

The information in this Chapter applies to you only if you are an Eligible Individual enrolled in the Fee-for-Service Dental Option. If you are enrolled in one of the DMO dental plans instead, see the separate booklet(s) issued by that organization for information on your dental benefits.

PLEASE NOTE: It is recommended that you request pre-authorization for treatment involving charges of \$500 or more. If your dental treatment is expected to cost \$500 or more, a dental claim form indicating the treatment plan and x-rays should be submitted to the Administrative Office, at the address below, before the services are performed.

Southwest Carpenters Health and Welfare Trust
P.O. Box 17973
Los Angeles, California 90017-0973

WHAT ARE THE BENEFITS?

The Plan will pay your Dentist in accordance with the amounts listed in the Schedule of Dental Allowances that appears at the end of this chapter for covered dental services, but not more than your Dentist's usual and customary fees. The maximum aggregate amount payable for covered dental services rendered to each Eligible Individual in any calendar year is \$1,500. This calendar year maximum does not include amounts applied toward the orthodontia lifetime maximum described below.

In some areas, the Trust maintains a panel of Dentists that have agreed to accept the Plan's dental allowances as payment in full for most services excluding orthodontia and lab fees. If you would like a listing of the panel Dentists and what areas they are available, please contact the Administrative Office.

The Fee-For-Service Dental Option provides a separate benefit for orthodontic procedures for your Dependent child. (Please note that orthodontia coverage is **not** provided for employees or their spouses under this dental plan.) Covered services are payable at 50% of Allowable Charges. Payments are made on a scheduled basis. The maximum aggregate amount payable for covered orthodontic procedures rendered to each Dependent child is \$1,500 per lifetime, whether or not there has been an interruption in coverage or change in eligibility status. For purposes of the \$1,500 maximum, an orthodontia treatment program begins with the placement of the initial orthodontic appliance.

Important Information About Providers of Dental Services

Orthodontic services other than diagnosis, consultation and x-rays, must be performed by a Dentist whose specialty is orthodontics, in order for benefits to be payable. All other covered dental services must be performed by a Dentist (general or specialist) or a dental hygienist under the supervision of a Dentist.

WHAT IS COVERED?

NOTE: Before treatment is started, be sure to discuss with your Dentist the total amount of his fee. Comparing his fee to the Schedule of Dental Allowances at the end of this Chapter, will enable you to determine what portion of the total bill you will be required to pay.

| | |
|---|--|
| DIAGNOSTIC | <p>Provides all the necessary procedures to assist the Dentist in evaluating the existing conditions to determine the required dental treatment.</p> <p>These services include office visits and consultations, clinical examinations, x-rays, biopsies, study models and vitality tests.</p> <p>Complete mouth x-rays will be allowed not more than once in 3 years unless they are necessary for orthodontic diagnosis or special need is shown. Supplementary bite-wing x-rays will be allowed upon request, but not more than once in any 12-month period unless special need is shown.</p> <p>Note: Any combination of x-rays taken on the same date of service is considered a full mouth set of x-rays.</p> |
| PREVENTIVE | <p>Prophylaxis will be covered once every 6 months and includes cleaning, scaling, polishing and application of fluoride solutions.</p> <p>Application of sealants will be covered once every 3 years to Eligible Individuals under the age of 16.</p> <p>Space maintainers will be covered.</p> |
| ORAL SURGERY | <p>Provides operative procedures in and about the oral cavity and jaws, e.g., extractions. Includes pre- and post-operative care.</p> |
| GENERAL ANESTHESIA | <p>General anesthesia is covered when administered for a covered oral surgery procedure performed by a Dentist who has a General Anesthesia Certificate issued by the California State Board of Dental Examiners.</p> |
| RESTORATIVE DENTISTRY | <p>Provides for the restoration of decayed, diseased or damaged natural teeth to a state of health, function and esthetics. This includes the use of amalgam, synthetic porcelain, plastic and/or bonded composite resin. Provides for the use of gold restorations and crowns and jackets when teeth cannot be restored with the preceding material.</p> |
| ENDODONTICS | <p>Provides necessary procedures for the treatment of diseases of the pulp chamber and pulp canals.</p> |
| PERIODONTICS | <p>Provides necessary procedures for the treatment of diseases of the tissues supporting the teeth.</p> |
| PROSTHODONTICS | <p>Provides for artificial replacement of missing natural teeth with bridges and partial and complete dentures.</p> <p>Prosthetic appliances will be replaced only if the existing appliance is unsatisfactory and cannot be made satisfactory and, if the Plan paid a benefit for the existing appliance, only after 5 years have elapsed from the date expense was incurred for the existing appliance.</p> |
| ORTHODONTIC SERVICES (DEPENDENT CHILDREN ONLY) | <p>Procedures to correct malalignment of teeth.</p> |

NOTE: In all cases in which there are optional plans of treatment involving different fees, the Plan will pay the applicable scheduled amount for the least expensive procedure.

If You Have Coverage Elsewhere

If you or your dependents have dental 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 “Coordination of Benefits and Reimbursement Obligation” in Chapter 10 for more information.

WHAT IS NOT COVERED?

In addition to the General Limitations and Exclusions listed in Chapter 10, benefits under the Fee-For-Service Dental Option are not payable for the following:

- congenital or developmental malformations or cosmetic surgery or Dentistry for purely cosmetic reasons, including, but not limited to, cleft palate, maxillary and mandibular malformations, enamel hypoplasia, fluorosis and anodontia
- orthodontic services except as otherwise provided for a Dependent child; a Dependent child must be an Eligible Individual and covered under this Fee-For-Service Dental Plan Option at the time of initial orthodontic banding in order for orthodontic coverage to be provided;
- prescribed drugs (*these may be covered by your prescription drug benefits*)
- Treatment of TMJ
- services or supplies payable under any other benefits provided by the Plan (*Payment for treatment of tumors or accidental injury will be made under this Dental Option only for expenses incurred in excess of all other benefits provided by the Plan including the HMO options*)

HOW TO FILE A CLAIM FOR BENEFITS UNDER THE FEE-FOR-SERVICE DENTAL OPTION

Claims for Services Other Than Orthodontia

- Obtain a claim form from the Administrative Office by calling (213) 385-0551 or toll-free (800) 252-9255. Be sure to specify that you need a claim for dental benefits, as the Plan has separate claim forms for medical, dental, and vision expenses. (*The Administrative Office will furnish your family Dentist with a supply of forms upon request.*) You can also get claim forms at your Local Union Office.
- On your first appointment, present a claim form with your portion completed advising your Dentist that you are covered by the Southwest Carpenters Health and Welfare Trust Fee-For-Service Dental Option.
- Have your Dentist complete the 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
- Forward the claim to:

Southwest Carpenters Health and Welfare Trust
P.O. Box 17973
Los Angeles, California 90017-0973

Claims for Orthodontic Services

For your Dependent child’s orthodontic services, please follow the preceding instructions. The timing of your claims submissions should be as follows:

- After the recommended pre-authorization is obtained from the Administrative Office, a claim should be submitted to the above address when the initial appliance is installed.
- Thereafter a claim should be submitted each month for the Orthodontist’s normal monthly charge until the maximum payment of \$1,500 for all orthodontic procedures has been reached.

Remember, services must be performed by a Dentist whose specialty is orthodontics in order for benefits to be payable from the Plan.

Deadline for 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.

See also, “Claims for Orthodontic Services” immediately above for guidelines on the timing of submission of claims for orthodontics.

Questions?

If you have any questions about submitting your claim, contact the Administrative Office.

For information on what to do if you disagree with the decision made in regard to your claim, see “Claims Review Procedures” in Chapter 10, “Other Important Plan Information.”

When a Separate Claim Form Is Required

You must submit a separate claim form for each person for whom benefits are payable. Be sure to include the member’s (Carpenter’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 within the past calendar year period. Mail any further bills or statements for any dental services covered by the Plan to the Administrative Office as soon as you receive them.

Frequently Asked Questions

Q Are there any dental benefits after I cease to be an Eligible Individual?

A In the event an Eligible Individual loses eligibility under the Trust, benefits will be payable for services rendered for the completion of procedures actually in progress at the time the patient was eligible, but not beyond 90 days following loss of eligibility. For example, if your eligibility terminates before dental work for prosthetic procedures (including bridges and crowns) has been completed, benefits for these procedures will be provided if the impression was made while you were eligible and the prosthetic appliance, bridge or crown is installed or delivered within 90 days after eligibility terminates. Prophylaxis and x-rays are not considered part of a treatment program.

Regarding orthodontics, if a Dependent child’s eligibility under the Plan terminates and he is receiving treatment for a service which is required for completion of a treatment program and such service is a covered orthodontic procedure, benefits will be payable for such service until the maximum payment of \$1,500 has been reached

SCHEDULE OF FEE-FOR-SERVICE DENTAL ALLOWANCES

| 2005 ADA Code | Procedure | Maximum Allowance (B/R means by report) |
|--|---|---|
| <u>CLINICAL ORAL EVALUATION</u> | | |
| 120 | PERIODIC ORAL EVALUATION | \$27 |
| 140 | LIMITED ORAL EVALUATION-PROBLEM FOCUSED | \$36 |
| 150 | COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT | \$45 |
| 160 | DETAILED AND EXTENSIVE ORAL EVALUATION-PROBLEM-FOCUSED | B/R |
| 170 | RE-EVALUATION - LIMITED, PROBLEM FOCUSED (ESTABLISHED PATIENT; NOT POST-OPERATIVE VISIT) | \$32 |
| 180 | COMPREHENSIVE PERIODONTAL EVALUATION - NEW OR ESTABLISHED PATIENT | \$40 |
| <u>RADIOGRAPHS</u> | | |
| 210 | INTRAORAL - COMPLETE SERIES (INCLUDING BITEWINGS) | \$69 |
| 220 | INTRAORAL - PERIAPICAL - FIRST FILM | \$14 |
| 230 | INTRAORAL - PERIAPICAL -EACH ADDITIONAL FILM | \$11 |
| 240 | INTRAORAL - OCCLUSAL FILM | \$22 |
| 250 | EXTRAORAL - FIRST FILM | \$25 |
| 260 | EXTRAORAL - EACH ADDITIONAL FILM | \$18 |
| 270 | BITEWING - SINGLE FILM | \$20 |
| 272 | BITEWINGS - TWO FILMS | \$22 |
| 274 | BITEWINGS - FOUR FILMS | \$32 |
| 277 | VERTICAL BITEWINGS - 7 TO 8 FILMS | \$44 |
| 290 | POSTERIOR - ANTERIOR OR LATERAL SKULL AND FACIAL BONE SURVEY FILM | \$74 |
| 310 | SIALOGRAPHY | \$117 |
| 320 | TEMPOROMANDIBULAR JOINT ARTHROGRAM, INCLUDING INJECTION | Not covered |
| 321 | OTHER TEMPOROMANDIBULAR JOINT FILMS | Not covered |
| 322 | TOMOGRAPHIC SURVEY | \$137 |
| 330 | PANORAMIC FILM (EXCLUDES BITEWINGS) | \$56 |
| 340 | CEPHALOMETRIC FILM | \$70 |
| 350 | ORAL/FACIAL PHOTOGRAPHIC IMAGES | Not covered |
| <u>TESTS AND EXAMINATIONS</u> | | |
| 415 | COLLECTION OF MICROORGANISMS FOR CULTURE AND SENSITIVITY | Not covered |
| 416 | VIRAL CULTURE | Not covered |
| 421 | GENETIC TEST FOR SUSCEPTIBILITY TO ORAL DISEASES | Not covered |
| 425 | CARIES SUSCEPTIBILITY TESTS | Not covered |
| 431 | ADJUNCTIVE PRE-DIAGNOSTIC TEST THAT AIDS IN DETECTION OF MUCOSAL ABNORMALITIES INCLUDING PREMALIGNANT AND MALIGNANT LESIONS, NOT TO INCLUDE CYTOLOGY OR BIOPSY PROCEDURES | Not covered |
| 460 | PULP VITALITY TEST | Not covered |
| 470 | DIAGNOSTIC CASTS | Not covered |

| 2005 ADA Code | Procedure | Maximum Allowance (B/R means by report) |
|--|--|--|
| <u>ORAL PATHOLOGY LABORATORY</u> <u>These may be covered under Medical Benefits</u> | | |
| 472 | ACCESSION OF TISSUE, GROSS EXAMINATION, PREPARATION AND TRANSMISSION OF WRITTEN REPORT | Not covered |
| 473 | ACCESSION OF TISSUE, GROSS AND MICROSCOPIC EXAMINATION, PREPARATION AND TRANSMISSION OF WRITTEN REPORT | Not covered |
| 474 | ACCESSION OF TISSUE, GROSS AND MICROSCOPIC EXAMINATION, INCLUDING ASSESSMENT OF SURGICAL MARGINS FOR PRESENCE OF DISEASE, PREPARATION AND TRANSMISSION OF WRITTEN REPORT | Not covered |
| 475 | DECALCIFICATION PROCEDURE | Not covered |
| 476 | SPECIAL STAINS FOR MICROORGANISMS | Not covered |
| 477 | SPECIAL STAINS, NOT FOR MICROORGANISMS | Not covered |
| 478 | IMMUNOHISTOCHEMICAL STAINS | Not covered |
| 479 | TISSUE IN-SITU HYBRIDIZATION, INCLUDING INTERPRETATION | Not covered |
| 480 | PROCESSING AND INTERPRETATION OF EXFOLIATIVE CYTOLOGIC SMEARS, INCLUDING THE PREPARATION AND TRANSMISSION OF WRITTEN REPORT | Not covered |
| 481 | ELECTRON MICROSCOPY - DIAGNOSTIC | Not covered |
| 482 | DIRECT IMMUNOFLUORESCENCE | Not covered |
| 483 | INDIRECT IMMUNOFLUORESCENCE | Not covered |
| 484 | CONSULTATION ON SLIDES PREPARED ELSEWHERE | Not covered |
| 485 | CONSULTATION, INCLUDING PREPARATION OF SLIDES FROM BIOPSY MATERIAL SUPPLIED BY REFERRING SOURCE | Not covered |
| 502 | OTHER ORAL PATHOLOGY PROCEDURES | B/R |
| 999 | UNSPECIFIED DIAGNOSTIC PROCEDURE | B/R |
| PREVENTIVE (01000-01999) | | |
| <u>DENTAL PROPHYLAXIS</u> | | |
| 1110 | PROPHYLAXIS - ADULT | \$50 |
| 1120 | PROPHYLAXIS - CHILD (UNDER AGE 14) | \$36 |
| <u>TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)</u> | | |
| 1201 | TOPICAL APPLICATION OF FLUORIDE (INCLUDING PROPHYLAXIS) - CHILD | \$51 |
| 1203 | TOPICAL APPLICATION OF FLUORIDE (PROPHYLAXIS NOT INCLUDED) - CHILD | \$15 |
| 1204 | TOPICAL APPLICATION OF FLUORIDE (PROPHYLAXIS NOT INCLUDED) - ADULT | \$15 |
| 1205 | TOPICAL APPLICATION OF FLUORIDE (INCLUDING PROPHYLAXIS) - ADULT | \$65 |
| <u>OTHER PREVENTIVE SERVICES</u> | | |
| 1310 | NUTRITIONAL COUNSELING FOR THE CONTROL OF DENTAL DISEASE | Not covered |
| 1320 | TOBACCO COUNSELING FOR THE CONTROL AND PREVENTION OF ORAL DISEASE | Not covered |
| 1330 | ORAL HYGIENE INSTRUCTIONS | Not covered |
| 1351 | SEALANT – PER TOOTH | \$27.00 up to \$61 per quadrant |

| 2005 ADA Code | Procedure | Maximum Allowance (B/R means by report) |
|---|---|--|
| <u>SPACE MAINTENANCE (PASSIVE APPLIANCES) -Allowances include adjustments within 6 months following installation</u> | | |
| 1510 | SPACE MAINTAINER – FIXED - UNILATERAL | \$178 |
| 1515 | SPACE MAINTAINER – FIXED - BILATERAL | \$247 |
| 1520 | SPACE MAINTAINER – REMOVABLE - UNILATERAL | \$237 |
| 1525 | SPACE MAINTAINER – REMOVABLE - BILATERAL | \$288 |
| 1550 | RECEMENTATION OF SPACE MAINTAINER | \$40 |
| RESTORATIVE (02000-02999) – Allowances for restorations include all bases, pulp caps, etc. | | |
| <u>AMALGAM RESTORATIONS (INCLUDING POLISHING)</u> | | |
| 2140 | AMALGAM - ONE SURFACE, PRIMARY OR PERMANENT | \$40 |
| 2150 | AMALGAM - TWO SURFACES, PRIMARY OR PERMANENT | \$53 |
| 2160 | AMALGAM - THREE SURFACES, PRIMARY OR PERMANENT | \$63 |
| 2161 | AMALGAM – FOUR OR MORE SURFACES, PRIMARY OR PERMANENT | \$76 |
| <u>RESIN RESTORATIONS – Allowances include any acid etch or other procedures</u> | | |
| 2330 | RESIN BASED COMPOSITE – ONE SURFACE, ANTERIOR | \$50 |
| 2331 | RESIN BASED COMPOSITE – TWO SURFACES, ANTERIOR | \$66 |
| 2332 | RESIN BASED COMPOSITE – THREE SURFACES, ANTERIOR | \$80 |
| 2335 | RESIN BASED COMPOSITE – FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR) | \$98 |
| 2390 | RESIN-BASED COMPOSITE CROWN, ANTERIOR | \$103 |
| 2391 | RESIN-BASED COMPOSITE - ONE SURFACE, POSTERIOR | \$40 |
| 2392 | RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR | \$53 |
| 2393 | RESIN-BASED COMPOSITE - THREE SURFACES, POSTERIOR | \$70 |
| 2394 | RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES, POSTERIOR | \$92 |
| <u>GOLD FOIL RESTORATIONS</u> | | |
| 2410 | GOLD FOIL – ONE SURFACE | \$226 |
| 2420 | GOLD FOIL – TWO SURFACES | \$278 |
| 2430 | GOLD FOIL – THREE SURFACES | \$289 |
| <u>INLAY/ONLAY RESTORATIONS</u> | | |
| 2510 | INLAY – METALLIC – ONE SURFACE | \$270 |
| 2520 | INLAY – METALLIC – TWO SURFACES | \$300 |
| 2530 | INLAY – METALLIC – THREE OR MORE SURFACES | \$335 |
| 2542 | ONLAY - METALLIC-TWO SURFACES | \$372 |
| 2543 | ONLAY – METALLIC – THREE SURFACES | \$378 |
| 2544 | ONLAY – METALLIC – FOUR OR MORE SURFACES | \$396 |
| 2610 | INLAY – PORCELAIN/CERAMIC – ONE SURFACE | \$314 |
| 2620 | INLAY – PORCELAIN/CERAMIC – TWO SURFACES | \$326 |
| 2630 | INLAY – PORCELAIN/CERAMIC – THREE OR MORE SURFACES | \$356 |
| 2642 | ONLAY – PORCELAIN/CERAMIC – TWO SURFACES | \$402 |
| 2643 | ONLAY – PORCELAIN/CERAMIC – THREE SURFACES | \$405 |

| 2005 ADA Code | Procedure | Maximum Allowance (B/R means by report) |
|--|---|--|
| 2644 | ONLAY – PORCELAIN/CERAMIC – FOUR OR MORE SURFACES | \$408 |
| 2650 | INLAY – COMPOSITE/RESIN – ONE SURFACE | \$277 |
| 2651 | INLAY – COMPOSITE/RESIN – TWO SURFACES | \$296 |
| 2652 | INLAY – COMPOSITE/RESIN – THREE OR MORE SURFACES | \$314 |
| 2662 | ONLAY – COMPOSITE/RESIN – TWO SURFACES | \$362 |
| 2663 | ONLAY – COMPOSITE/RESIN – THREE SURFACES | \$355 |
| 2664 | ONLAY – COMPOSITE/RESIN – FOUR OR MORE SURFACES | \$376 |
| <u>CROWNS – SINGLE RESTORATION ONLY</u> | | |
| 2710 | CROWN – RESIN BASED COMPOSITE (INDIRECT) | \$212 |
| 2712 | CROWN - RESIN-BASED COMPOSITE (INDIRECT) | \$212 |
| 2720 | CROWN – RESIN WITH HIGH NOBLE METAL | \$393 |
| 2721 | CROWN – RESIN WITH PREDOMINATELY BASE METAL | \$382 |
| 2722 | CROWN – RESIN WITH NOBLE METAL | \$398 |
| 2740 | CROWN – PORCELAIN/CERAMIC SUBSTRATE | \$394 |
| 2750 | CROWN – PORCELAIN FUSED TO HIGH NOBLE METAL | \$405 |
| 2751 | CROWN – PORCELAIN FUSED TO PREDOMINANTLY BASE METAL | \$366 |
| 2752 | CROWN – PORCELAIN FUSED TO NOBLE METAL | \$382 |
| 2780 | CROWN - 3/4 CAST HIGH NOBLE METAL | \$377 |
| 2781 | CROWN - 3/4 CAST PREDOMINANTLY BASE METAL | \$363 |
| 2782 | CROWN - 3/4 CAST NOBLE METAL | \$369 |
| 2783 | CROWN - 3/4 PORCELAIN/CERAMIC | \$380 |
| 2790 | CROWN – FULL CAST HIGH NOBLE METAL | \$396 |
| 2791 | CROWN – FULL CAST PREDOMINANTLY BASE METAL | \$365 |
| 2792 | CROWN – FULL CAST NOBLE METAL | \$375 |
| 2794 | CROWN - TITANIUM | \$396 |
| 2799 | PROVISIONAL CROWN | Not covered |
| <u>OTHER RESTORATIVE SERVICES</u> | | |
| 2910 | RECEMENT INLAY, ONLAY, OR PARTIAL COVERAGE RESTORATION | \$35 |
| 2915 | RECEMENT CAST OR PREFABRICATED POST AND CORE | \$35 |
| 2920 | RECEMENT CROWN | \$35 |
| 2930 | PREFABRICATED STAINLESS STEEL CROWN – PRIMARY TOOTH | \$93 |
| 2931 | PREFABRICATED STAINLESS STEEL CROWN – PERMANENT TOOTH | \$111 |
| 2932 | PREFABRICATED RESIN CROWN | \$111 |
| 2933 | PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW | \$75 |
| 2934 | PREFABRICATED ESTHETIC COATED STAINLESS STEEL CROWN - PRIMARY TOOTH | \$93 |
| 2940 | SEDATIVE FILLING | Not covered |
| 2950 | CORE BUILDUP, INCLUDING ANY PINS | Not covered |
| 2951 | PIN RETENTION – PER TOOTH, IN ADDITION TO RESTORATION | \$24 |
| 2952 | CAST POST AND CORE IN ADDITION TO CROWN | \$158 |
| 2953 | EACH ADDITIONAL CAST POST - SAME TOOTH | \$109 |

| 2005 ADA Code | Procedure | Maximum Allowance (B/R means by report) |
|---|---|--|
| 2954 | PREFABRICATED POST AND CORE IN ADDITION TO CROWN | \$119 |
| 2955 | POST REMOVAL (NOT IN CONJUNCTION WITH ENDODONTIC THERAPY) | \$99 |
| 2957 | EACH ADDITIONAL PREFABRICATED POST - SAME TOOTH | \$116 |
| 2960 | LABIAL VENEER (LAMINATE) - CHAIRSIDE | \$203 |
| 2961 | LABIAL VENEER (RESIN LAMINATE) - LABORATORY | \$291 |
| 2962 | LABIAL VENEER (PORCELAIN LAMINATE) - LABORATORY | \$330 |
| 2971 | ADDITIONAL PROCEDURES TO CONSTRUCT NEW CROWN UNDER EXISTING PARTIAL DENTURE FRAMEWORK | B/R |
| 2975 | COPING | \$275 |
| 2980 | CROWN REPAIR | B/R |
| 2999 | UNSPECIFIED RESTORATIVE PROCEDURE | B/R |
| ENDODONTICS (03000-03999) | | |
| <u>PULP CAPPING</u> | | |
| 3110 | PULP CAP – DIRECT (EXCLUDING FINAL RESTORATION) | Not covered |
| 3120 | PULP CAP – INDIRECT (EXCLUDING FINAL RESTORATION) | Not covered |
| <u>PULPOTOMY</u> | | |
| 3220 | THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION) - REMOVAL OF PULP CORONAL TO THE DENTINOCEMENTAL JUNCTION AND APPLICATION OF MEDICAMENT | \$62 |
| 3221 | PULPAL DEBRIDEMENT, PRIMARY AND PERMANENT TEETH | \$81 |
| <u>ENDODONTIC THERAPY ON PRIMARY TEETH</u> | | |
| 3230 | PULPAL THERAPY (RESORTABLE FILLING) – ANTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION) | \$97 |
| 3240 | PULPAL THERAPY (RESORTABLE FILLING) – POSTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION) | \$118 |
| <u>ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES, AND FOLLOW-UP CARE)</u> <u>Includes primary teeth without succedaneous teeth and permanent teeth</u> | | |
| 3310 | ANTERIOR (EXCLUDING FINAL RESTORATION) | \$231 |
| 3320 | BICUSPID (EXCLUDING FINAL RESTORATION) | \$270 |
| 3330 | MOLAR (EXCLUDING FINAL RESTORATION) | \$346 |
| 3331 | TREATMENT OF ROOT CANAL OBSTRUCTION; NON-SURGICAL ACCESS | \$83 |
| 3332 | INCOMPLETE ENDODONTIC THERAPY; INOPERABLE, UNRESTORABLE OR FRACTURED TOOTH | \$48 |
| 3333 | INTERNAL ROOT REPAIR OF PERFORATION DEFECTS | \$55 |
| <u>ENDODONTIC RETREATMENT</u> | | |
| 3346 | RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - ANTERIOR | \$264 |
| 3347 | RETREATMENT OF PREVIOUS ROOT CANAL THERAPY – BICUSPID | \$296 |
| 3348 | RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - MOLAR | \$166 |
| <u>APEXIFICATION/RECALCIFICATION PROCEDURES</u> | | |
| 3351 | APEXIFICATION/RECALCIFICATION – INITIAL VISIT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC.) | \$128 |

| 2005 ADA Code | Procedure | Maximum Allowance (B/R means by report) |
|---|---|--|
| 3352 | APEXIFICATION/RECALCIFICATION – INTERIM MEDICATION REPLACEMENT (APICAL CLOSURE/ CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC.) | \$90 |
| 3353 | APEXIFICATION/RECALCIFICATION – FINAL VISIT (INCLUDES COMPLETED ROOT CANAL THERAPY APICAL CLOSURE/CALCIFIC OF PERFORATIONS, ROOT RESORPTION, ETC.) | \$166 |
| <u>APICOECTOMY/PERIAPICAL SERVICES</u> | | |
| 3410 | APICOECTOMY/PERIRADICULAR SURGERY - ANTERIOR | \$212 |
| 3421 | APICOECTOMY/PERIRADICULAR SURGERY – BICUSPID (FIRST ROOT) | \$262 |
| 3425 | APICOECTOMY/PERIRADICULAR SURGERY – MOLAR (FIRST ROOT) | \$284 |
| 3426 | APICOECTOMY/PERIRADICULAR SURGERY – (EACH ADDITIONAL ROOT) | \$135 |
| 3430 | RETROGRADE FILLING – PER ROOT | \$117 |
| 3450 | ROOT AMPUTATION – PER ROOT | \$165 |
| 3460 | ENDODONTIC ENOSSEOUS IMPLANT | \$579 |
| 3470 | INTENTIONAL REIMPLANTATION (INCLUDING NECESSARY SPLINTING) | \$272 |
| <u>OTHER ENDODONTIC PROCEDURES</u> | | |
| 3910 | SURGICAL PROCEDURE FOR ISOLATION OF TOOTH WITH RUBBER DAM | \$60 |
| 3920 | HEMISECTION (INCLUDING ANY ROOT REMOVAL), NOT INCLUDING ROOT CANAL THERAPY | \$168 |
| 3950 | CANAL PREPARATION AND FITTING OF PREFORMED DOWEL OR POST | \$85 |
| 3999 | UNSPECIFIED ENDODONTIC PROCEDURE | B/R |
| <u>SURGICAL SERVICES (INCLUDING USUAL POST OPERATIVE CARE)</u> | | |
| 4210 | GINGIVECTOMY OR GINGIVOPLASTY - FOUR OR MORE CONTIGUOUS TEETH OR BOUNDED TEETH SPACES PER QUADRANT | \$250 |
| 4211 | GINGIVECTOMY OR GINGIVOPLASTY - ONE TO THREE CONTIGUOUS TEETH OR BOUNDED TEETH SPACES PER QUADRANT | \$78 |
| 4240 | GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING - FOUR OR MORE CONTIGUOUS TEETH OR BOUNDED TEETH SPACES PER QUADRANT | \$275 |
| 4241 | GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING - ONE TO THREE CONTIGUOUS TEETH OR BOUNDED TEETH SPACES PER QUADRANT | \$108 |
| 4245 | APICALLY POSITIONED FLAP | \$424 |
| 4249 | CLINICAL CROWN LENGTHENING – HARD TISSUE | \$258 |
| 4260 | OSSEOUS SURGERY (INCLUDING FLAP ENTRY AND CLOSURE) - FOUR OR MORE CONTIGUOUS TEETH OR BOUNDED TEETH SPACES PER QUADRANT | \$387 |
| 4261 | OSSEOUS SURGERY (INCLUDING FLAP ENTRY AND CLOSURE) - ONE TO THREE CONTIGUOUS TEETH OR BOUNDED TEETH SPACES PER QUADRANT | \$210 |
| 4263 | BONE REPLACEMENT GRAFT – FIRST SITE IN QUADRANT | \$235 |
| 4264 | BONE REPLACEMENT GRAFT – EACH ADDITIONAL SITE IN QUADRANT | \$210 |
| 4265 | BIOLOGIC MATERIALS TO AID IN SOFT AND OSSEOUS TISSUE REGENERATION | \$120 |
| 4266 | GUIDED TISSUE REGENERATION – RESORBABLE BARRIER, PER SITE | \$345 |
| 4267 | GUIDED TISSUE REGENERATION – NONRESORBABLE BARRIER, PER SITE (INCLUDES MEMBRANE REMOVAL) | \$232 |
| 4268 | SURGICAL REVISION PROCEDURE, PER TOOTH | \$140 |
| 4270 | PEDICLE SOFT TISSUE GRAFT PROCEDURE | \$301 |
| 4271 | FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE SURGERY) | \$313 |
| 4273 | SUBEPITHELIAL CONNECTIVE TISSUE GRAFT PROCEDURE, PER TOOTH | \$429 |

| 2005 ADA Code | Procedure | Maximum Allowance (B/R means by report) |
|--|---|--|
| 4274 | DISTAL OR PROXIMAL WEDGE PROCEDURE (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA) | \$150 |
| 4275 | SOFT TISSUE ALLOGRAFT | \$344 |
| 4276 | COMBINED CONNECTIVE TISSUE AND DOUBLE PEDICLE GRAFT, PER TOOTH | \$387 |
| <u>NON-SURGICAL PERIODONTAL SERVICE</u> | | |
| 4320 | PROVISIONAL SPLINTING - INTRACORONAL | Not covered |
| 4321 | PROVISIONAL SPLINTING - EXTRACORONAL | Not covered |
| 4341 | PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT | \$89 |
| 4342 | PERIODONTAL SCALING AND ROOT PLANING - ONE TO THREE TEETH PER QUADRANT | \$45 |
| 4355 | FULL MOUTH DEBRIDEMENT TO ENABLE COMPREHENSIVE PERIODONTAL EVALUATION AND DIAGNOSIS | \$69 |
| 4381 | LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER TOOTH, BY REPORT | B/R |
| <u>OTHER PERIODONTAL SERVICES</u> | | |
| 4910 | PERIODONTAL MAINTENANCE PROCEDURES (FOLLOWING ACTIVE THERAPY) | \$50 |
| 4920 | UNSCHEDULED DRESSING CHANGE (BY SOMEONE OTHER THAN TREATING DENTIST) | \$38 |
| 4999 | UNSPECIFIED PERIODONTAL PROCEDURE | B/R |
| PROSTHODONTICS (REMOVABLE) (05000-05899) | | |
| <u>COMPLETE DENTURES (INCLUDING ROUTINE POST DELIVERY CARE)</u> | | |
| 5110 | COMPLETE DENTURE – MAXILLARY | \$540 |
| 5120 | COMPLETE DENTURE – MANDIBULAR | \$544 |
| 5130 | IMMEDIATE DENTURE – MAXILLARY | \$584 |
| 5140 | IMMEDIATE DENTURE – MANDIBULAR | \$584 |
| <u>PARTIAL DENTURES (INCLUDING ROUTINE POST DELIVERY CARE)</u> | | |
| 5211 | MAXILLARY PARTIAL DENTURE – RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH) | \$447 |
| 5212 | MANDIBULAR PARTIAL DENTURE – RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH) | \$453 |
| 5213 | MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH) | \$584 |
| 5214 | MANDIBULAR PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH) | \$582 |
| 5225 | MAXILLARY PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS AND TEETH) | \$447 |
| 5226 | MANDIBULAR PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS AND TEETH) | \$453 |
| 5281 | REMOVABLE UNILATERAL PARTIAL DENTURE – ONE PIECE CAST METAL (INCLUDING CLASPS AND TEETH) | \$360 |
| <u>ADJUSTMENTS TO DENTURES</u> | | |
| 5410 | ADJUST COMPLETE DENTURE - MAXILLARY | \$30 |
| 5411 | ADJUST COMPLETE DENTURE - MANDIBULAR | \$30 |
| 5421 | ADJUST PARTIAL DENTURE - MAXILLARY | \$30 |
| 5422 | ADJUST PARTIAL DENTURE - MANDIBULAR | \$30 |

| 2005 ADA Code | Procedure | Maximum Allowance (B/R means by report) |
|---|--|--|
| <u>REPAIRS TO COMPLETE DENTURES</u> | | |
| 5510 | REPAIR BROKEN COMPLETE DENTURE BASE | \$69 |
| 5520 | REPLACE MISSING OR BROKEN TEETH – COMPLETE DENTURE (EACH TOOTH) | \$59 |
| <u>REPAIRS TO PARTIAL DENTURES</u> | | |
| 5610 | REPAIR RESIN DENTURE BASE | \$72 |
| 5620 | REPAIR CAST FRAMEWORK | \$104 |
| 5630 | REPAIR OR REPLACE BROKEN CLASP | \$93 |
| 5640 | REPLACE BROKEN TEETH – PER TOOTH | \$59 |
| 5650 | ADD TOOTH TO EXISTING PARTIAL DENTURE | \$80 |
| 5660 | ADD CLASP TO EXISTING PARTIAL DENTURE | \$105 |
| 5670 | REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MAXILLARY) | \$415 |
| 5671 | REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MANDIBULAR) | \$487 |
| <u>DENTURE REBASE PROCEDURES</u> | | |
| 5710 | REBASE COMPLETE MAXILLARY DENTURE | \$209 |
| 5711 | REBASE COMPLETE MANDIBULAR DENTURE | \$209 |
| 5720 | REBASE MAXILLARY PARTIAL DENTURE | \$202 |
| 5721 | REBASE MANDIBULAR PARTIAL DENTURE | \$202 |
| <u>DENTURE RELINE PROCEDURES</u> | | |
| 5730 | RELIN COMPLETE MAXILLARY DENTURE (CHAIRSIDE) | \$132 |
| 5731 | RELIN COMPLETE MANDIBULAR DENTURE (CHAIRSIDE) | \$132 |
| 5740 | RELIN MAXILLARY PARTIAL DENTURE (CHAIRSIDE) | \$120 |
| 5741 | RELIN MANDIBULAR PARTIAL DENTURE (CHAIRSIDE) | \$120 |
| 5750 | RELIN COMPLETE MAXILLARY DENTURE (LABORATORY) | \$174 |
| 5751 | RELIN COMPLETE MANDIBULAR DENTURE (LABORATORY) | \$171 |
| 5760 | RELIN MAXILLARY PARTIAL DENTURE (LABORATORY) | \$171 |
| 5761 | RELIN MANDIBULAR PARTIAL DENTURE (LABORATORY) | \$171 |
| <u>INTERIM PROSTHESIS</u> | | |
| 5810 | INTERIM COMPLETE DENTURE (MAXILLARY) | Not covered |
| 5811 | INTERIM COMPLETE DENTURE (MANDIBULAR) | Not covered |
| 5820 | INTERIM PARTIAL DENTURE (MAXILLARY) | Not covered |
| 5821 | INTERIM PARTIAL DENTURE (MANDIBULAR) | Not covered |
| <u>OTHER REMOVABLE PROSTHETIC SERVICES</u> | | |
| 5850 | TISSUE CONDITIONING (MAXILLARY) | \$67 |
| 5851 | TISSUE CONDITIONING (MANDIBULAR) | \$75 |
| 5860 | OVERDENTURE - COMPLETE | B/R |
| 5861 | OVERDENTURE – PARTIAL | B/R |
| 5862 | PRECISION ATTACHMENT | Not covered |
| 5867 | REPLACEMENT OF REPLACEABLE PART OF SEMI-PRECISION OR PRECISION ATTACHMENT (MALE OR FEMALE COMPONENT) | \$68 |
| 5875 | MODIFICATION OF REMOVABLE PROSTHESIS FOLLOWING IMPLANT SURGERY | \$64 |

| 2005 ADA Code | Procedure | Maximum Allowance (B/R means by report) |
|---------------------|--|--|
| 5899 | UNSPECIFIED REMOVABLE PROSTHODONTIC PROCEDURE | B/R |
| 5900 | MAXILLOFACIAL PROSTHETICS | Not covered |
| 5911 | FACIAL MOULAGE (SECTIONAL) | Not covered |
| 5912 | FACIAL MOULAGE (COMPLETE) | Not covered |
| 5913 | NASAL PROSTHESIS | Not covered |
| 5914 | AURICULAR PROSTHESIS | Not covered |
| 5915 | ORBITAL PROSTHESIS | Not covered |
| 5916 | OCULAR PROSTHESIS | Not covered |
| 5919 | FACIAL PROSTHESIS | Not covered |
| 5922 | NASAL SEPTAL PROSTHESIS | Not covered |
| 5923 | OCULAR PROSTHESIS, INTERIM | Not covered |
| 5924 | CRANIAL PROSTHESIS | Not covered |
| 5925 | FACIAL AUGMENTATION IMPLANT PROSTHESIS | Not covered |
| 5926 | NASAL PROSTHESIS, REPLACEMENT | Not covered |
| 5927 | AURICULAR PROSTHESIS, REPLACEMENT | Not covered |
| 5928 | ORBITAL PROSTHESIS, REPLACEMENT | Not covered |
| 5929 | FACIAL PROSTHESIS, REPLACEMENT | Not covered |
| 5931 | OBTURATOR PROSTHESIS, SURGICAL | Not covered |
| 5932 | OBTURATOR PROSTHESIS, DEFINITIVE | Not covered |
| 5933 | OBTURATOR PROSTHESIS, MODIFICATION | Not covered |
| 5934 | MANDIBULAR RESECTION PROSTHESIS WITH GUIDE FLANGE | Not covered |
| 5935 | MANDIBULAR RESECTION PROSTHESIS WITHOUT GUIDE FLANGE | Not covered |
| 5936 | OBTURATOR PROSTHESIS, INTERIM | Not covered |
| 5937 | TRISMUS APPLIANCE (NOT FOR TMD TREATMENT) | Not covered |
| 5951 | FEEDING AID | Not covered |
| 5952 | SPEECH AID PROSTHESIS, PEDIATRIC | Not covered |
| 5953 | SPEECH AID PROSTHESIS, ADULT | Not covered |
| 5954 | PALATAL AUGMENTATION PROSTHESIS | Not covered |
| 5955 | PALATAL LIFT PROSTHESIS, DEFINITIVE | Not covered |
| 5958 | PALATAL LIFT PROSTHESIS, INTERIM | Not covered |
| 5959 | PALATAL LIFT PROSTHESIS, MODIFICATION | Not covered |
| 5960 | SPEECH AID PROSTHESIS, MODIFICATION | Not covered |
| 5982 | SURGICAL STENT | Not covered |
| 5983 | RADIATION CARRIER | Not covered |
| 5984 | RADIATION SHIELD | Not covered |
| 5985 | RADIATION CONE LOCATOR | Not covered |
| 5986 | FLUORIDE GEL CARRIER | Not covered |
| 5987 | COMMISSURE SPLINT | Not covered |
| 5988 | SURGICAL SPLINT | \$332 |
| 5999 | UNSPECIFIED MAXILLOFACIAL PROSTHESIS, BY REPORT | Not covered |

| 2005 ADA Code | Procedure | Maximum Allowance (B/R means by report) |
|--|--|--|
| <u>IMPLANT SERVICES (06000-06199)</u> | | |
| 6010 | SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT | \$900 |
| 6040 | SURGICAL PLACEMENT: EPOSTEAL IMPLANT | \$1,500 |
| 6050 | SURGICAL PLACEMENT: TRANSOSTEAL IMPLANT | \$1,500 |
| <u>IMPLANT SUPPORTED PROSTHETICS</u> | | |
| 6053 | IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR COMPLETELY EDENTULOUS ARCH | \$630 |
| 6054 | IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH | \$567 |
| 6055 | DENTAL IMPLANT SUPPORTED CONNECTING BAR | \$893 |
| 6056 | PREFABRICATED ABUTMENT - INCLUDES PLACEMENT | \$378 |
| 6057 | CUSTOM ABUTMENT - INCLUDES PLACEMENT | \$378 |
| 6058 | ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN | \$523 |
| 6059 | ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL) | \$525 |
| 6060 | ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINANTLY BASE METAL) | \$439 |
| 6061 | ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL) | \$521 |
| 6062 | ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL) | \$525 |
| 6063 | ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINANTLY BASE METAL) | \$423 |
| 6064 | ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL) | \$499 |
| 6065 | IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN | \$581 |
| 6066 | IMPLANT SUPPORTED PORCELAIN FUSED TO METAL CROWN (TITANIUM, TITANIUM ALLOY, HIGH NOBLE METAL) | \$543 |
| 6067 | IMPLANT SUPPORTED METAL CROWN (TITANIUM, TITANIUM ALLOY, HIGH NOBLE METAL) | \$519 |
| 6068 | ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD | \$497 |
| 6069 | ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL) | \$510 |
| 6070 | ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINANTLY BASE METAL) | \$423 |
| 6071 | ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE METAL) | \$486 |
| 6072 | ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL) | \$517 |
| 6073 | ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINANTLY BASE METAL) | \$395 |
| 6074 | ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL) | \$480 |
| 6075 | IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD | \$498 |
| 6076 | IMPLANT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (TITANIUM, TITANIUM ALLOY, OR HIGH NOBLE METAL) | \$498 |
| 6077 | IMPLANT SUPPORTED RETAINER FOR CAST METAL FPD (TITANIUM, TITANIUM ALLOY, OR HIGH NOBLE METAL) | \$501 |
| 6078 | IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR COMPLETELY EDENTULOUS ARCH | \$660 |
| 6079 | IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH | \$630 |
| <u>OTHER IMPLANT SERVICES</u> | | |
| 6080 | IMPLANT MAINTENANCE PROCEDURES, INCLUDING: REMOVAL OF PROSTHESIS, CLEANSING OF PROSTHESIS AND ABUTMENTS, REINSERTION OF PROSTHESIS | \$108 |
| 6090 | REPAIR IMPLANT SUPPORTED PROSTHESIS | B/R |
| 6094 | ABUTMENT SUPPORTED CROWN - (TITANIUM) | \$542 |
| 6095 | REPAIR IMPLANT ABUTMENT | B/R |

| 2005 ADA Code | Procedure | Maximum Allowance (B/R means by report) |
|---|--|--|
| 6100 | IMPLANT REMOVAL | Not covered |
| 6190 | RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT | B/R |
| 6194 | ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - (TITANIUM) | \$522 |
| 6199 | UNSPECIFIED IMPLANT PROCEDURE | B/R |
| PROSTHODONTICS, FIXED (06200-06999) | | |
| <u>FIXED PARTIAL DENTURE PONTICS</u> | | |
| 6205 | PONTIC - INDIRECT RESIN BASED COMPOSITE | \$216 |
| 6210 | PONTIC – CAST HIGH NOBLE METAL | \$390 |
| 6211 | PONTIC – CAST PREDOMINANTLY BASE METAL | \$360 |
| 6212 | PONTIC – CAST NOBLE METAL | \$375 |
| 6214 | PONTIC - TITANIUM | \$390 |
| 6240 | PONTIC – PORCELAIN FUSED TO HIGH NOBLE METAL | \$404 |
| 6241 | PONTIC – PORCELAIN FUSED TO PREDOMINANTLY BASE METAL | \$365 |
| 6242 | PONTIC – PORCELAIN FUSED TO NOBLE METAL | \$377 |
| 6245 | PONTIC - PORCELAIN/CERAMIC | \$393 |
| 6250 | PONTIC – RESIN WITH HIGH NOBLE METAL | \$393 |
| 6251 | PONTIC – RESIN WITH PREDOMINANTLY BASE METAL | \$366 |
| 6252 | PONTIC – RESIN WITH NOBLE METAL | \$384 |
| 6253 | PROVISIONAL PONTIC | Not covered |
| <u>FIXED PARTIAL DENTURE RETAINERS-INLAYS/ONLAYS</u> | | |
| 6545 | RETAINER – CASE METAL FOR RESIN BONDED FIXED PROSTHESIS | \$240 |
| 6548 | RETAINER - PORCELAIN/CERAMIC FOR RESIN BONDED FIXED PROSTHESIS | \$302 |
| 6600 | INLAY - PORCELAIN/CERAMIC, TWO SURFACES | \$360 |
| 6601 | INLAY - PORCELAIN/CERAMIC, THREE OR MORE SURFACES | \$393 |
| 6602 | INLAY - CAST HIGH NOBLE METAL, TWO SURFACES | \$215 |
| 6603 | INLAY - CAST HIGH NOBLE METAL, THREE OR MORE SURFACES | \$235 |
| 6604 | INLAY - CAST PREDOMINANTLY BASE METAL, TWO SURFACES | \$186 |
| 6605 | INLAY - CAST PREDOMINANTLY BASE METAL, THREE OR MORE SURFACES | \$203 |
| 6606 | INLAY - CAST NOBLE METAL, TWO SURFACES | \$194 |
| 6607 | INLAY - CAST NOBLE METAL, THREE OR MORE SURFACES | \$215 |
| 6624 | INLAY - TITANIUM | \$235 |
| 6608 | ONLAY -PORCELAIN/CERAMIC, TWO SURFACES | \$368 |
| 6609 | ONLAY - PORCELAIN/CERAMIC, THREE OR MORE SURFACES | \$403 |
| 6610 | ONLAY - CAST HIGH NOBLE METAL, TWO SURFACES | \$235 |
| 6611 | ONLAY - CAST HIGH NOBLE METAL, THREE OR MORE SURFACES | \$258 |
| 6612 | ONLAY - CAST PREDOMINANTLY BASE METAL, TWO SURFACES | \$206 |
| 6613 | ONLAY - CAST PREDOMINANTLY BASE METAL, THREE OR MORE SURFACES | \$226 |
| 6614 | ONLAY - CAST NOBLE METAL, TWO SURFACES | \$215 |
| 6615 | ONLAY - CAST NOBLE METAL, THREE OR MORE SURFACES | \$235 |
| 6634 | ONLAY - TITANIUM | \$258 |

| 2005 ADA Code | Procedure | Maximum Allowance (B/R means by report) |
|---|--|--|
| <u>FIXED PARTIAL DENTURE RETAINERS CROWN</u> | | |
| 6710 | CROWN - INDIRECT RESIN BASED COMPOSITE | \$212 |
| 6720 | CROWN – RESIN WITH HIGH NOBLE METAL | \$398 |
| 6721 | CROWN – RESIN WITH PREDOMINANTLY BASE METAL | \$380 |
| 6722 | CROWN – RESIN WITH NOBLE METAL | \$390 |
| 6740 | CROWN - PORCELAIN/CERAMIC | \$392 |
| 6750 | CROWN – PORCELAIN FUSED TO HIGH NOBLE METAL | \$405 |
| 6751 | CROWN – PORCELAIN FUSED TO PREDOMINANTLY BASE METAL | \$374 |
| 6752 | CROWN – PORCELAIN FUSED TO NOBLE METAL | \$376 |
| 6780 | CROWN – 3/4 CAST HIGH NOBLE METAL | \$383 |
| 6781 | CROWN - 3/4 CAST PREDOMINANTLY BASE METAL | \$394 |
| 6782 | CROWN - 3/4 CAST NOBLE METAL | \$392 |
| 6783 | CROWN - 3/4 PORCELAIN/CERAMIC | \$398 |
| 6790 | CROWN – FULL CAST HIGH NOBLE METAL | \$397 |
| 6791 | CROWN – FULL CAST PREDOMINANTLY BASE METAL | \$360 |
| 6792 | CROWN – FULL CAST NOBLE METAL | \$380 |
| 6794 | CROWN - TITANIUM | \$396 |
| 6793 | PROVISIONAL RETAINER CROWN | Not covered |
| <u>OTHER FIXED PARTIAL DENTURE SERVICES</u> | | |
| 6920 | CONNECTOR BAR | \$446 |
| 6930 | RECEMENT FIXED PARTIAL DENTURE | \$53 |
| 6940 | STRESS BREAKER | \$151 |
| 6950 | PRECISION ATTACHMENT | Not covered |
| 6970 | CAST POST AND CORE IN ADDITION TO FIXED PARTIAL DENTURE RETAINER | \$158 |
| 6971 | CASE POST AS PART OF FIXED PARTIAL DENTURE RETAINER | \$135 |
| 6972 | PREFABRICATED POST AND CORE IN ADDITION TO FIXED PARTIAL DENTURE RETAINER | \$119 |
| 6973 | CORE BUILD UP FOR RETAINER, INCLUDING ANY PINS | Not covered |
| 6975 | COPING - METAL | \$275 |
| 6976 | EACH ADDITIONAL CAST POST - SAME TOOTH | \$110 |
| 6977 | EACH ADDITIONAL PREFABRICATED POST - SAME TOOTH | \$52 |
| 6980 | FIXED PARTIAL DENTURE REPAIR | B/R |
| 6985 | PEDIATRIC PARTIAL DENTURE, FIXED | B/R |
| 6999 | UNSPECIFIED FIXED PROSTHODONTIC PROCEDURE | B/R |
| <u>EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POST OPERATIVE CARE)</u> | | |
| 7111 | EXTRACTION, CORONAL REMNANTS - DECIDUOUS TOOTH | \$65 |
| 7140 | EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL) | \$65 |

| 2005 ADA Code | Procedure | Maximum Allowance (B/R means by report) |
|--|--|--|
| <u>SURGICAL EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POST OPERATIVE CARE)</u> | | |
| 7210 | SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING ELEVATION OF MUCOPERIOSTEAL FLAP AND REMOVAL OF BONE AND/OR SECTION OF TOOTH | \$98 |
| 7220 | REMOVAL OF IMPACTED TOOTH – SOFT TISSUE | \$108 |
| 7230 | REMOVAL OF IMPACTED TOOTH – PARTIALLY BONY | \$150 |
| 7240 | REMOVAL OF IMPACTED TOOTH – COMPLETELY BONY | \$179 |
| 7241 | REMOVAL OF IMPACTED TOOTH – COMPLETELY BONY, WITH UNUSUAL SURGICAL COMPLICATIONS | \$219 |
| 7250 | SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE) | \$109 |
| <u>OTHER SURGICAL PROCEDURES</u> | | |
| 7260 | OROANTRAL FISTULA CLOSURE | \$325 |
| 7261 | PRIMARY CLOSURE OF A SINUS PERFORATION | \$228 |
| 7270 | TOOTH REIMPLANTATION AND/OR STABILIZATION OF AL CIDENTLY AVULSED OR DISPLACED TOOTH | \$195 |
| 7272 | TOOTH TRANSPLANTATION (INCLUDES REIMPLANTATION FROM ONE SITE TO ANOTHER AND SPLINTING AND/OR STABILIZATION) | \$300 |
| 7280 | SURGICAL ACCESS OF AN UNERUPTED TOOTH | \$166 |
| 7282 | MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION | \$168 |
| 7283 | PLACEMENT OF DEVICE TO FACILITATE ERUPTION OF IMPACTED TOOTH | B/R |
| 7285 | BIOPSY OF ORAL TISSUE - HARD | \$134 |
| 7286 | BIOPSY OF ORAL TISSUE - SOFT | \$109 |
| 7287 | EXFOLIATIVE CYTOLOGICAL SAMPLE COLLECTION | \$53 |
| 7288 | BRUSH BIOPSY - TRANSEPIHELIAL SAMPLE COLLECTION | \$109 |
| 7290 | SURGICAL REPOSITIONING OF TEETH | \$198 |
| 7291 | TRANSSEPTAL FIBEROTOMY/SUPRA CRESTAL FIBEROTOMY | B/R |
| <u>ALVEOPLASTY – SURGICAL PREPARATION OF RIDGE FOR DENTURES</u> | | |
| 7310 | ALVEOPLASTY IN CONJUNCTION WITH EXTRACTION – PER QUADRANT | \$108 |
| 7311 | ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT | \$108 |
| 7320 | ALVEOPLASTY NOT IN CONJUNCTION WITH EXTRACTION – PER QUADRANT | \$164 |
| 7321 | ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT | \$164 |
| <u>VESTIBULOPLASTY</u> | | |
| 7340 | VESTIBULOPLASTY – RIDGE EXTENSION (SECONDARY EPITHELIALIZATION) | \$408 |
| 7350 | VESTIBULOPLASTY – RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT, AND MANAGEMENT OF HYPERTROPHIED AND HYPERPLASTIC TISSUE) | \$1,500 |
| <u>SURGICAL EXCISION OF SOFT TISSUE LESIONS</u> | | |
| 7410 | RADICAL EXCISION – LESION DIAMETER UP TO 1.25 CM | \$121 |
| 7411 | EXCISION OF BENIGN LESION GREATER THAN 1.25 CM | \$146 |
| 7412 | EXCISION OF BENIGN LESION, COMPLICATED | \$160 |
| 7413 | EXCISION OF MALIGNANT LESION UP TO 1.25 CM | \$220 |

| 2005 ADA Code | Procedure | Maximum Allowance (B/R means by report) |
|---------------------|--|--|
| 7414 | EXCISION OF MALIGNANT LESION GREATER THAN 1.25 CM | \$252 |
| 7415 | EXCISION OF MALIGNANT LESION, COMPLICATED | \$280 |
| | <u>SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS</u> | |
| 7440 | EXCISION OF MALIGNANT TUMOR – LESION DIAMETER UP TO 1.25 CM | \$270 |
| 7441 | EXCISION OF MALIGNANT TUMOR – LESION DIAMETER GREATER THAN 1.25 CM | \$310 |
| 7450 | REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM | \$165 |
| 7451 | REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN 1.25 CM | \$245 |
| 7460 | REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM | \$122 |
| 7461 | REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN 1.25 CM | \$141 |
| 7465 | DESTRUCTION OF LESION(S) BY PHYSICAL OR CHEMICAL METHOD | B/R |
| | <u>EXCISION OF BONE TISSUE</u> | |
| 7471 | REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE) | \$156 |
| 7472 | REMOVAL OF TORUS PALATINUS | \$156 |
| 7473 | REMOVAL OF TORUS MANDIBULARIS | \$156 |
| 7485 | SURGICAL REDUCTION OF OSSEOUS TUBEROSITY | \$120 |
| 7490 | RADICAL RESECTION OF MANDIBLE WITH BONE GRAFT | \$1,500 |
| | <u>SURGICAL INCISION</u> | |
| 7510 | INCISION AND DRAINAGE OF ABSCESS – INTRAORAL SOFT TISSUE | \$73 |
| 7511 | INCISION AND DRAINAGE OF ABSCESS - INTRAORAL SOFT TISSUE - COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES) | B/R |
| 7520 | INCISION AND DRAINAGE OF ABSCESS – EXTRAORAL SOFT TISSUE | \$122 |
| 7521 | INCISION AND DRAINAGE OF ABSCESS - EXTRAORAL SOFT TISSUE - COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES) | B/R |
| 7530 | REMOVAL OF FOREIGN BODY, SKIN OR SUBSUTANEOUS AREOLAR TISSUE | \$95 |
| 7540 | REMOVAL OF REACTION – PRODUCING FOREIGN BODIES – MUSCULOSKELETAL SYSTEM | \$125 |
| 7550 | PARTIAL OSTECTOMY/SEQUESTRECTOMY FOR REMOVAL OF NON-VITAL BONE | \$180 |
| 7560 | MAXILLARY SINUSOTOMY FOR REMOVAL OF TOOTH FRAGMENTS OR FOREIGN BODY | \$434 |
| | <u>TREATMENT OF FRACTURES - SIMPLE</u> | |
| 7610 | MAXILLA - OPEN REDUCTION (TEETH IMMOBILIZED, IF PRESENT) | Not covered |
| 7620 | MAXILLA - CLOSED REDUCTION (TEETH IMMOBILIZED, IF PRESENT) | Not covered |
| 7630 | MANDIBLE - OPEN REDUCTION (TEETH IMMOBILIZED, IF PRESENT) | Not covered |
| 7640 | MANDIBLE - CLOSED REDUCTION (TEETH IMMOBILIZED, IF PRESENT) | Not covered |
| 7650 | MALAR AND/OR ZYGOMATIC ARCH - OPEN REDUCTION | Not covered |
| 7660 | MALAR AND/OR ZYGOMATIC ARCH - CLOSED REDUCTION | Not covered |
| 7670 | ALVEOLUS CLOSED REDUCTION MAY INCLUDE STABILIZATION OF TEETH | Not covered |
| 7671 | ALVEOLUS, OPEN REDUCTION MAY INCLUDE STABILIZATION OF TEETH | Not covered |
| 7680 | FACIAL BONES - COMPLICATED REDUCTION WITH FIXATION AND MULTIPLE SURGICAL APPROACHES | Not covered |
| | <u>TREATMENT OF FRACTURES - COMPOUND</u> | |
| 7710 | MAXILLA OPEN REDUCTION | Not covered |
| 7720 | MAXILLA - CLOSED REDUCTION | Not covered |
| 7730 | MANDIBLE - OPEN REDUCTION | Not covered |

| 2005 ADA Code | Procedure | Maximum Allowance (B/R means by report) |
|--|---|--|
| 7740 | MANDIBLE - CLOSED REDUCTION | Not covered |
| 7750 | MALAR AND/OR ZYGOMATIC ARCH - OPEN REDUCTION | Not covered |
| 7760 | MALAR AND/OR ZYGOMATIC ARCH - CLOSED REDUCTION | Not covered |
| 7770 | ALVEOLUS - OPEN REDUCTION STABILIZATION OF TEETH | Not covered |
| 7771 | ALVEOLUS, CLOSED REDUCTION STABILIZATION OF TEETH | Not covered |
| 7780 | FACIAL BONES - COMPLICATED REDUCTION WITH FIXATION AND MULTIPLE SURGICAL APPROACHES | Not covered |
| <u>REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR JOINT DYSFUNCTIONS</u> | | |
| 7810 | OPEN REDUCTION OF DISLOCATION | Not covered |
| 7820 | CLOSED REDUCTION OF DISLOCATION | Not covered |
| 7830 | MANIPULATION UNDER ANESTHESIA | Not covered |
| 7840 | CONDYLECTOMY | Not covered |
| 7850 | SURGICAL DISCECTOMY, WITH/WITHOUT IMPLANT | Not covered |
| 7852 | DISC REPAIR | Not covered |
| 7854 | SYNOVECTOMY | Not covered |
| 7856 | MYOTOMY | Not covered |
| 7858 | JOINT RECONSTRUCTION | Not covered |
| 7860 | ARTHROTOMY | Not covered |
| 7865 | ARTHROPLASTY | Not covered |
| 7870 | ARTHROCENTESIS | Not covered |
| 7871 | NON-ARTHROSCOPIC LYSIS AND LAVAGE | Not covered |
| 7872 | ARTHROSCOPY - DIAGNOSIS, WITH OR WITHOUT BIOPSY | Not covered |
| 7873 | ARTHROSCOPY - SURGICAL: LAVAGE AND LYSIS OF ADHESIONS | Not covered |
| 7874 | ARTHROSCOPY - SURGICAL: DISC REPOSITIONING AND STABILIZATION | Not covered |
| 7875 | ARTHROSCOPY - SURGICAL: SYNOVECTOMY | Not covered |
| 7876 | ARTHROSCOPY - SURGICAL: DISCECTOMY | Not covered |
| 7877 | ARTHROSCOPY - SURGICAL: DEBRIDEMENT | Not covered |
| 7880 | OCCLUSAL ORTHOTIC DEVICE, BY REPORT | Not covered |
| 7899 | UNSPECIFIED TMD THERAPY, BY REPORT | Not covered |
| <u>REPAIR OF TRAUMATIC WOUNDS</u> | | |
| 7910 | SUTURE OF RECENT SMALL WOUNDS UP TO 5 CM | \$111 |
| <u>COMPLICATED SUTURING (RECONSTRUCTION REQUIRING DELICATE HANDLING OF TISSUES AND WIDE UNDERMINING FOR METICULOUS CLOSURE)</u> | | |
| 7911 | COMPLICATED SUTURE – UP TO 5 CM | \$125 |
| 7912 | COMPLICATED SUTURE – GREATER THAN 5 CM | \$142 |
| <u>OTHER REPAIR PROCEDURES</u> | | |
| 7920 | SKIN GRAFT (IDENTIFY DEFECT COVERED, LOCATION AND TYPE OF GRAFT) | Not covered |
| 7940 | OSTEOPLASTY – FOR ORTHOGNATHIC DEFORMITIES | Not covered |
| 7941 | OSTEOTOMY - MANDIBULAR RAMI | Not covered |

| 2005 ADA Code | Procedure | Maximum Allowance (B/R means by report) |
|---|---|--|
| 7943 | OSTEOTOMY - MANDIBULAR RAMI WITH BONE GRAFT; INCLUDES OBTAINING THE GRAFT | Not covered |
| 7944 | OSTEOTOMY – SEGMENTED OR SUBAPICAL PER SEXTANT OR QUADRANT | Not covered |
| 7945 | OSTEOTOMY – BODY OF MANDIBLE | Not covered |
| 7946 | LEFORT I (MAXILLA – TOTAL) | Not covered |
| 7947 | LEFORT I (MAXILLA – SEGMENTED) | Not covered |
| 7948 | LEFORT II OR LEFORT III (OSTEOPLASTY OF FACIAL BONE FOR MIDFACE HYPOPLASIA OR RETRUSION) WITHOUT BONE GRAFT | Not covered |
| 7949 | LEFORT II OR LEFORT III – WITH BONE GRAFT | Not covered |
| 7950 | OSSEOUS, OSTEOPERIOSTEAL, OR CARTILAGE GRAFT OF THE MANDIBLE OR FACIAL BONES AUTOGENOUS OR NONAUTOGENOUS | Not covered |
| 7953 | BONE REPLACEMENT GRAFT FOR RIDGE PRESERVATION - PER SITE | Not covered |
| 7955 | REPAIR OF MAXILLOFACIAL SOFT AND HARD TISSUE DEFECT | Not covered |
| 7960 | FRENULECTOMY (FRENECTOMY OR FRENOTOMY) – SEPARATE PROCEDURE | \$150 |
| 7963 | FRENULOPLASTY | \$150 |
| 7970 | EXCISION OF HYPERPLASTIC TISSUE – PER ARCH | \$199 |
| 7971 | EXCISION OF PERICORONAL GINGIVA | \$90 |
| 7972 | SURGICAL REDUCTION OF FIBROUS TUBEROSITY | \$109 |
| 7980 | SIATOLLTHOTOMY | Not covered |
| 7981 | EXCISION OF SALIVARY GLAND | B/R |
| 7982 | SIALODOCHOPLASTY | Not covered |
| 7983 | CLOSURE OF SALIVARY FISTULA | \$661 |
| 7990 | EMERGENCY TRACHEOTOMY | Not covered |
| 7991 | CORONOLDESTOMY | Not covered |
| 7995 | SYNTHETIC GRAFT – MANDIBLE OR FACIAL BONES | Not covered |
| 7996 | IMPLANT – MANDIBLE FOR AUGMENTATION PURPOSE (EXCLUDING ALVEOLAR RIDGE) | Not covered |
| 7997 | APPLIANCE REMOVAL (NOT BY DENTIST WHO PLACED APPLIANCE), INCLUDES REMOVAL OF ARCHBAR | B/R |
| 7999 | UNSPECIFIED ORAL SURGERY PROCEDURE | B/R |
| <u>ADJUNCTIVE GENERAL SERVICES (09000-09999)</u> | | |
| <u>UNCLASSIFIED TREATMENT</u> | | |
| 9110 | PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN – MINOR PROCEDURE | \$42 |
| <u>ANESTHESIA</u> | | |
| 9210 | LOCAL ANESTHESIA NOT IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES | Not covered |
| 9211 | REGIONAL BLOCK ANESTHESIA | Not covered |
| 9212 | TRIGOMINAL DIVISION BLOCK ANESTHESIA | Not covered |
| 9215 | LOCAL ANESTHESIA | Not covered |
| 9220 | GENERAL ANESTHESIA – FIRST 30 MINUTES | \$160 |
| 9221 | GENERAL ANESTHESIA – EACH ADDITIONAL 15 MINUTES | \$59 |
| 9230 | ANALGESIA | Not covered |
| 9241 | INTRAVENOUS CONSCIOUS SEDATION/ANALGESIA - FIRST 30 MINUTES | \$161 |
| 9242 | INTRAVENOUS CONSCIOUS SEDATION/ANALGESIA - EACH ADDITIONAL 15 MINUTES | \$73 |
| 9248 | NON-INTRAVENOUS CONSCIOUS SEDATION | Not covered |

| 2005 ADA Code | Procedure | Maximum Allowance (B/R means by report) |
|---|--|--|
| <u>PROFESSIONAL CONSULTATION</u> | | |
| 9310 | CONSULTATION (DIAGNOSTIC SERVICE PROVIDED BY DENTIST OR PHYSICIAN OTHER THAN PRACTITIONER PROVIDING TREATMENT) | \$45 |
| <u>PROFESSIONAL VISITS</u> | | |
| 9410 | HOUSE/EXTENDED CARE FACILITY CALL | \$60 |
| 9420 | HOSPITAL CALL | \$64 |
| 9430 | OFFICE VISIT FOR OBSERVATION (DURING REGULARLY SCHEDULED HOURS) – NO OTHER SERVICES PERFORMED | \$27 |
| 9440 | OFFICE VISIT – AFTER REGULARLY SCHEDULED HOURS | \$51 |
| 9450 | CASE PRESENTATION, DETAILED AND EXTENSIVE TREATMENT PLANNING | Not covered |
| <u>DRUGS</u> | | |
| 9610 | THERAPEUTIC DRUG INJECTION | Not covered |
| 9630 | OTHER DRUGS AND/OR MEDICAMENTS | Not covered |
| <u>MISCELLANEOUS SERVICES</u> | | |
| 9910 | APPLICATION OF DESENSITIZING MEDICAMENT | Not covered |
| 9911 | APPLICATION OF DESENSITIZING RESIN FOR CERVICAL AND/OR ROOT SURFACE, PER TOOTH | Not covered |
| 9920 | BEHAVIOR MANAGEMENT | Not covered |
| 9930 | TREATMENT OF COMPLICATIONS (POST-SURGICAL) – UNUSUAL CIRCUMSTANCES | B/R |
| 9940 | OCCLUSAL GUARD | B/R |
| 9941 | FABRICATION OF ATHLETIC MOUTHGUARD | Not covered |
| 9942 | REPAIR AND/OR RELINE OF OCCLUSAL GUARD | B/R |
| 9950 | OCCLUSION ANALYSIS – MOUNTED CASE | Not covered |
| 9951 | OCCLUSAL ADJUSTMENT – LIMITED | Not covered |
| 9952 | OCCLUSAL ADJUSTMENT – COMPLETE | Not covered |
| 9970 | ENAMEL MICROABRASION | Not covered |
| 9971 | ODONTOPLASTY 1 - 2 TEETH; INCLUDES REMOVAL OF ENAMEL PROJECTIONS | Not covered |
| 9972 | EXTERNAL BLEACHING - PER ARCH | Not covered |
| 9973 | EXTERNAL BLEACHING - PER TOOTH | Not covered |
| 9974 | INTERNAL BLEACHING - PER TOOTH | Not covered |
| 9999 | UNSPECIFIED ADJUNCTIVE PROCEDURE | B/R |

Chapter 6

EMPLOYEE WEEKLY DISABILITY BENEFITS SUMMARY

In this Chapter you'll find:

- Who is eligible for the benefit
- What the benefit is
- Limitations and Exclusions
- When benefits terminate
- Information on filing claims

*The information in this Chapter applies only to active Carpenters who are Eligible Individuals or would be Eligible Individuals if the lag month between a work quarter and an eligibility quarter (as described in Chapter 1) did not exist and are **not covered by any state disability insurance or program (commonly called SDI)** involving employer and/or employee contributions. In general, California employees are covered under California SDI if they work for an employer(s) located in California and have had SDI payroll deductions for at least six months. COBRA and most Special Class Employees are not covered under the Weekly Disability Benefit regardless of whether or not they are covered by any SDI or similar program. Disability benefits are also not payable to participants who are receiving a pension benefit from any Carpenters Pension Plan.*

WHAT ARE THE BENEFITS?

If a Carpenter becomes disabled as a result of sickness or accidental bodily injury, and as a result of such disability he/she is “unable to work,” the Plan will pay him/her \$150 per week (minus FICA deductions). The weekly benefit amount will be prorated for partial weeks of disability. Benefits will be paid only if the Carpenter or Nevada Administrative Office non-bargaining employee becomes disabled while in Eligible Individual status under the Plan or would be in Eligible Individual status if it were not for the lag month between a work quarter and eligibility quarter.

For a Carpenter, “unable to work” means being unable to perform work described in the applicable collective bargaining agreement.

Benefit payments will begin on the eighth day of disability and will continue only for the duration of the disability but not to exceed a maximum of 26 weeks for any one period of disability. Benefits will only be paid based on the 1st 30 day's of disability, regardless of a longer period of time as may be indicated on the original disability form. In order for additional benefits to be paid, the member must have his doctor complete one of the extension forms, for every month thereafter until reaching the last day of the disability's maximum allowance or end of the medical disability period, which ever comes first.

All disabilities will be considered one period of disability unless the disabilities are due to entirely unrelated causes and are separated by a return to active employment on a full-time basis, or availability for such employment as shown on the out-of-work list provided under the collective bargaining agreement that covers the Carpenter.

LIMITATIONS

This Weekly Disability benefit is subject to the following limitations:

- The amount of weekly benefit will be reduced by any benefit to which you are entitled from any other group coverage, state mandated disability benefit or other governmental plan whether funded by employer or employee contributions.
- No period of disability shall be considered to have started until the day the individual has been seen and treated personally by a Physician. In order for benefits to be payable you must be receiving regular care and be personally seen by the attending Physician at least once a month.

EXCLUSIONS

No Weekly Disability benefits are payable for:

- A self-inflicted injury, including attempted suicide, unless the Plan is notified of a health related cause that is the source of the injury and is a protected source of injury under applicable federal law (for example, the Health Insurance Portability and Accountability Act).
- A disability resulting from war, or any act of war.

- Any injury sustained or sickness contracted anywhere except within the United States, its territories or possessions, Canada or Mexico.
- A disability resulting from an airplane flight except as a passenger of an aircraft having an airworthiness certificate and operated by a licensed pilot.
- A disability resulting from the commission of a felony or engaging in an illegal occupation.
- Any disability directly related to the continuing use of alcohol, barbiturates, hypnotics, LSD, or any type of addiction, as determined by the patient’s medical records.
- Accidental bodily injury arising out of or in the course of employment, or a sickness entitling you to benefits under workers’ compensation or similar legislation.
- A disability resulting from work for remuneration or profit.

TERMINATION OF BENEFITS

Weekly Disability benefits will cease immediately upon the occurrence of any of the following events:

- A return to work, or being released by your attending Physician as able to return to work (there is no “light duty” in Bargaining Unit work). Placing your name on the “out-of-work” list will be construed to mean you are able to return to work.
- Termination of the benefit by the Board of Trustees.
- Termination of your Eligible Individual status under the Plan, even if COBRA continuation coverage is selected. The Weekly Disability Benefit is not provided to anyone enrolled in COBRA continuation coverage.
- Entering into any type of work for profit, whether it’s bargaining unit work or not.
- Certification by your Physician or the Trust’s medical consultant that you are no longer unable to work.
- Expiration of the maximum benefit period as described under “What are the Benefits?”.

HOW TO FILE A CLAIM FOR EMPLOYEE WEEKLY DISABILITY BENEFITS

Certification from your Physician (not chiropractor) covering the occurrence, the character and the extent of your disability must be furnished to the Administrative Office. The necessary claim form can be obtained from the Administrative Office by calling (213) 385-0551 or (800) 252-9255. Send the completed claim form to:

Southwest Carpenters Health and Welfare Trust
Attn: Weekly Disability Claims
533 S. Fremont Ave.
Los Angeles, CA 90071

Or, for Nevada participants

Southwest Carpenters Health and Welfare Trust
980 Kelly Johnson Drive, Suite 180
Las Vegas, NV 89119

Proof of ineligibility for any SDI may also be required. Ongoing verification as requested by the Administrative Office will be required.

Deadline for Submission

You must submit your claim **within 90 days** from the date your disability began. Failure to file your claim within 90 days will invalidate your claim.

Questions?

If you have any questions about submitting your claim, contact the Administrative Office.

For information on what to do if you disagree with the decision made in regard to your claim, see “Claims Review Procedures” in Chapter 10, “Other Important Plan Information.”

Chapter 7

EMPLOYEE LIFE INSURANCE SUMMARY

In this Chapter you'll find:

- What the benefit is
- Your beneficiary
- How to continue your life insurance if you lose eligibility
- 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 (and it applies regardless of which medical benefit option under the Plan covers them). COBRA participants are NOT covered by this benefit.

WHAT ARE THE BENEFITS?

In the event of your death from any cause while you are an Eligible Individual, a total of \$10,000 of group term life insurance will be paid to the beneficiary(ies) listed on your most recently signed life insurance beneficiary card on file at the Administrative Office.

YOUR BENEFICIARY

Be certain that you have completed a life insurance beneficiary card 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. You may request a change of beneficiary at any time by submitting a new beneficiary card to the Administrative Office. Beneficiary cards are available from the Administrative Office or your local Union office. 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.

The beneficiary you designate for life insurance is also your beneficiary for the accidental death benefit (see Chapter 9, "Accidental Death and Dismemberment Summary").

HOW TO CONTINUE YOUR LIFE INSURANCE IF YOU LOSE ELIGIBILITY

If your eligibility terminates while the Prudential 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.

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 Prudential, 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.

If you want to take advantage of this arrangement contact Prudential at the following address and include the Trust's group number, 91029, in your correspondence:

The Prudential Insurance Company
Group Conversions
West Mt. Pleasant Avenue
Mail Stop NJ 11-01-03
Livingston, NJ 07039-2729

NOTE: If you re-establish your active eligibility under the Plan and then lose that eligibility once again, you can not 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, carrying your Social Security number, to the Administrative Office immediately.

The insurance company will make payment of the claim promptly upon receipt of all necessary proofs.

If your beneficiary disagrees with the payment decision made in regard to the claim, he or she can request a review of the decision. Please alert your beneficiary to the claims review information provided in Chapter 10 of this booklet.

All death certificates and correspondence should be submitted to the Administrative Office or satellite office at:

California:

Administrative Office
533 South Fremont Avenue
Los Angeles, CA 90071-1706
(213) 386-8590
(800) 293-1370

Arizona:

Satellite Office
4547 W. Mc Dowell Rd.
Phoenix, AZ 85035-4121
(602) 352-6805

Utah:

Satellite Office
8149 S. Welby Park Dr.
West Jordan, UT 84088
(801) 282-6528

Nevada:

Administrative Office
980 Kelly Johnson Drive, Suite 180
Las Vegas, NV 89119
(702) 851-4510
(800) 501-0210

Chapter 8

DEPENDENT LIFE INSURANCE SUMMARY

In this Chapter you'll find:

- What the benefit is
- Beneficiary
- How your spouse may continue her or his life insurance if you lose eligibility
- 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 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.

WHAT ARE THE BENEFITS?

Benefits are payable in the following amounts in the event of the death of eligible Dependents from any cause while the employee from whom they derive Dependent status is an Eligible Individual.

| Eligible Family Members | Schedule of Amounts |
|-------------------------|---------------------|
| Spouse | \$1,500 |
| Each child | \$1,500 |

Note: In the case of an infant death, the child must have been born alive in order for a benefit to be payable.

BENEFICIARY

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).

HOW YOUR SPOUSE MAY CONTINUE LIFE INSURANCE IF YOU LOSE ELIGIBILITY

If your eligibility terminates while the Prudential Master Group Insurance policy remains in force, or if you die, any insurance then in effect on your spouse's life may be converted to any type of individual life insurance policy then customarily being issued by Prudential, except term insurance or any policy containing disability benefits, without your spouse's having to furnish evidence of good health. To convert the insurance, you or your spouse must make application to Prudential within 31 days from the termination of your spouse's insurance. The premiums will be the same as you or your spouse would ordinarily pay if your spouse applied for an individual policy at that time.

If you want to take advantage of this arrangement contact Prudential at the following address and include the Trust's group number, 91029, in your correspondence:

The Prudential Insurance Company
Group Conversions
West Mt. Pleasant Avenue
Mail Stop NJ 11-01-03
Livingston, NJ 07039-2729

NOTE: If you re-establish your active eligibility under the Trust and then lose that eligibility once again, you or your spouse can not convert the spouse's group term life insurance to an individual policy if the spouse already has an individual policy in effect as a result of a previous conversion.

The life insurance benefit for your spouse will be paid if the death of your spouse occurs during the period in which application for conversion may be made. The life insurance benefit for your child(ren) will be paid if the death of your child(ren) occurs during the 31-day period following termination of insurance resulting from termination of your eligibility.

Frequently Asked Questions

Q Can life insurance for my children be converted to individual policies?

A No, conversion of the life insurance benefit for children is not available.

HOW TO FILE A CLAIM FOR DEPENDENT LIFE INSURANCE

Whenever there is a claim, a certified copy of the death certificate, carrying the deceased's Social Security number, should be sent to the Administrative Office immediately.

The insurance company will make payment of the claim promptly upon receipt of all necessary proofs.

For information on what to do if you disagree with the decision made in regard to your claim, see "Claims Review Procedures" in Chapter 10, "Other Important Plan Information."

All death certificates and correspondence should be submitted to the Administrative Office or Satellite Office at:

California:

Administrative Office
533 South Fremont Avenue
Los Angeles, CA 90071-1706
(213) 386-8590
(800) 293-1370

Arizona:

Satellite Office
4547 W. Mc Dowell Rd.
Phoenix, AZ 85035-4121
(602) 352-6805

Utah:

Satellite Office
8149 S. Welby Park Dr.
West Jordan, UT 84088
(801) 282-6528

Nevada:

Administrative Office
980 Kelly Johnson Drive, Suite 180
Las Vegas, NV 89119
(702) 851-4510
(800) 501-0210

Chapter 9

EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS SUMMARY

In this Chapter you'll find:

- What the benefits are
- 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 are NOT covered for this benefit, nor are Dependents.

WHAT ARE THE 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 90 days after such injury. Payment will be made regardless of any other benefits you may receive.

| Description of Loss | Benefit Payable |
|--|-------------------------------------|
| Your death | \$10,000 (Paid to your beneficiary) |
| Loss of both of your hands | \$10,000 (Paid to you) |
| Loss of both of your feet | \$10,000 (Paid to you) |
| Loss of sight in both of your eyes | \$10,000 (Paid to you) |
| Loss of one of your hands and one of your feet | \$10,000 (Paid to you) |
| Loss of one of your hands and sight in one of your eyes | \$10,000 (Paid to you) |
| Loss of one of your feet and sight in one of your eyes | \$10,000 (Paid to you) |
| Loss of one of your hands | \$5,000 (Paid to you) |
| Loss of one of your feet | \$5,000 (Paid to you) |
| Loss of sight in one of your eyes | \$5,000 (Paid to you) |

The payment for all losses caused by any one accident may not be more than the full amount of your insurance-\$10,000, but the benefits paid on account of one loss will not prevent further payment for losses resulting from subsequent accidents.

Loss of a hand or foot means loss by severance at or above the wrist or ankle and loss of sight means total and irrecoverable loss of sight.

YOUR BENEFICIARY

Your beneficiary for the accidental death benefit is the same as your beneficiary for your life insurance. As noted in Chapter 7, you can name any person or persons as your beneficiary. You may request a change of beneficiary at any time by submitting a new beneficiary card. Beneficiary cards are available from the Administrative Office or your local Union office.

WHAT IS NOT COVERED?

Losses must not result

- from suicide or attempted suicide whether you are sane or not,
- directly or indirectly from disease or medical or surgical treatment thereof,
- from ptomaine or bacterial infection, except only septic infection of and through a visible wound accidentally sustained, or
- from a state of war, an act of war or an insurrection or participation in a riot.

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.

If you or your beneficiary disagrees with the payment decision made in regard to the claim, it can be appealed as explained in “Claims Review Procedures” in Chapter 10 of this booklet. Please alert your beneficiary to the existence of that information in this booklet.

All death certificates and correspondence should be submitted to the Administrative Office or Satellite Office at:

California:

Administrative Office
533 South Fremont Avenue
Los Angeles, CA 90071-1706
(213) 386-8590
(800) 293-1370

Arizona:

Satellite Office
4547 W. Mc Dowell Rd.
Phoenix, AZ 85035-4121
(602) 352-6805

Utah:

Satellite Office
8149 S. Welby Park Dr.
West Jordan, UT 84088
(801) 282-6528

Nevada:

Administrative Office
980 Kelly Johnson Drive, Suite 180
Las Vegas, NV 89119
(702) 851-4510
(800) 501-0210

OTHER IMPORTANT PLAN INFORMATION

This Chapter includes:

- Medicare and Plan benefits
- Coordination of benefits and reimbursement obligation
- Privacy of health information
- Claims review procedures
- Factors that could affect your receipt of benefits
- General limitations and exclusions
- Your rights under ERISA
- General Plan information
- Plan facts

MEDICARE AND PLAN BENEFITS

If you are an active member and covered by Medicare, this Plan will generally pay benefits first. Medicare may provide backup coverage for some care if Plan benefits do not pay the full cost. In technical terms, the Trust is “primary” for your covered hospital and medical expenses and Medicare is “secondary.” (See “*Coordination of Benefits and Reimbursement Obligation*” below for a discussion of primary and secondary payers.) You have, however, as required by government regulations, the option to reject the Trust as primary provider for your hospital and medical coverage. If you wish 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 card.

When you Retire

The Trust’s retiree medical options (Fee-For-Service and HMOs) are not available to anyone 65 years of age or older or anyone who is otherwise entitled to Medicare (regardless of whether or not they are actually enrolled in Medicare).

If you are planning to retire soon it is recommended that you contact the Administrative Office so they can help you determine what post-retirement health and welfare benefits will be available to you and your family.

COORDINATION OF BENEFITS AND REPAYMENT OBLIGATION

The information below applies to the Fee-for-Service Medical, Dental and Vision Options including the Spectera Vision Care Coverage. If you are in one of the HMOs or DMOs, 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. 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.

The Fee-For-Service Options have been designed to help you meet the cost of preventative care, disease or injury. Since it is not intended that you receive greater benefits than the actual Allowable Charges incurred, the hospital, medical, dental and vision benefits under the Fee-For-Service Options will be coordinated with those provided to the employee Eligible Individual and his Dependents by any other group benefit or service plan. These rules do not apply to the Fee-for-Service Prescription Drug Benefits.

Coordination of benefits generally works as follows:

- If the Plan's Fee-For-Service Option is primary (pays first), it will pay its regular benefits.
- If it is secondary (pays after the other plan covering the person), it will pay a reduced benefit which, when added to the benefit paid by the other plan, will not exceed the highest amount allowed among the two plans for the service rendered. In no event, however, will this Plan pay more than what it would have paid in the absence of another plan nor will it pay more than what the patient would have been responsible to pay in the absence of this Plan.

For example, if the claim is for services rendered by a provider that has a contracted fee arrangement under the other plan, this Plan will only pay up to the patient's portion of that contracted fee. Any charges in excess of a provider's contracted fee under the other plan in the absence of this Plan will not be considered by this Plan to be an allowable amount under this Plan or the other plan for purposes of determining the highest amount allowed among the two plans.

If another plan is primary under this Plan's rules, and it contains a provision capping its benefits for an Eligible Individual or his Dependents having the effect of shifting coverage liability to this Plan in a manner designed to avoid the usual operation of this Plan's coordination of benefit rules, this Plan shall not be liable to provide benefits until the other plan provides as primary plan its customary benefits determined without regard to such cap.

The following is an excerpt from the Plan Document that describes the rules for determining which plan pays first...

The rules establishing the order of benefit determination are:

- (1) A Plan which covers the person on whose expense claim is based that does not contain a coordination of benefits provision or a provision similar to the intent of a coordination of benefits provision, shall determine its benefits before the benefits of a Plan which has such a provision.
- (2) The benefits of a Plan which covers the person on whose expense claim is based as an active employee shall be determined before the benefits of a Plan which covers such person as a laid-off or retired employee or as a dependent.
- (3) The benefits of a Plan which covers the person on whose expense claim is based as a dependent of an active employee shall be determined before the benefits of a Plan which covers such person as a dependent of a laid-off or retired employee.
- (4) When both Plans cover the person on whose expense claim is based as a dependent child of an active employee, or when both Plans cover the person on whose expense claim is based as a dependent child of a laid-off or retired employee, the benefits of the Plan which covers the parent whose birthday (month and day only) occurs first during a Calendar year shall be determined before the benefits of the Plan which covers the parent whose birthday (month and day only) occurs later in the year, except that in the event a father and mother are legally separated or divorced, the following rules shall apply:
 - a. the benefits of a Plan which covers the person on whose expense claim is based as a dependent child of the parent with financial responsibility for the child's medical expenses by virtue of a court decree shall be determined first;
 - b. if there is no court decree, the benefits of a Plan which covers the person on whose expense claim is based as a dependent child of the parent with legal custody shall be determined first;
 - c. if there is no court decree and the parent with legal custody has remarried, the order of benefit determination shall be as follows:
 1. the Plan which covers the parent with legal custody;
 2. the Plan which covers the step-parent with legal custody; and
 3. the Plan which covers the parent without legal custody.
- (5) When the other plan which covers the person on whose expense claim is based is Medicare, then the benefits of This Plan shall be determined before the benefits of Medicare unless the applicable provisions of Federal Law specifically permit otherwise.
- (6) Payment for benefits with respect to an Eligible Individual will be made in accordance with any assignment of rights made by or on behalf of such Eligible Individual as required by a state plan for medical assistance approved under Section 1912(a)(1)(A) of Title XIX of the Social Security Act, as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993 (a "Medicaid Plan"). The fact that an individual is eligible for or is provided medical

assistance under a Medicaid Plan shall not be taken into consideration in the determination or making of any payments to or on behalf of an Eligible Individual under the Plan. To the extent that payment has been made under a Medicaid Plan for benefits that would otherwise be payable under this Plan, payment from the Plan shall be made in accordance with any state law that provides that the state has acquired the rights with respect to an Eligible Individual to such payment.

(7) When a person on whose expense claim is based is covered by This Plan or another Plan under the terms of the continuation of coverage requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) and as amended from time to time, then the following order of benefit determination shall be used:

- a. The Plan covering the person on a basis other than that of a Qualified Beneficiary under the terms of COBRA (or a dependent of a Qualified Beneficiary) pays benefits before the Plan covering the person as a Qualified Beneficiary (or a dependent of a Qualified Beneficiary);
- b. When both Plans cover the person as a Qualified Beneficiary under the terms of COBRA (or a dependent of a Qualified Beneficiary), the Plan which has covered the person for the longer period of time pays benefits before the Plan which has covered him the shorter period of time.

(d) When the rules set forth in subsection (c) of this Section 3 do not establish an order of benefit determination, the benefits of a Plan which has covered the person on whose expense claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered such person the shorter period of time.

If you have questions about whether the Trust's plan is primary or secondary, call the Administrative Office at (213) 386-8590.

Obligation to Repay the Trust Out of Third Party Recoveries

When a person accepts Eligible Individual status by enrolling in the Plan, this means the Eligible Individual agrees to repay to the Trust the amount of expenses paid by the Trust for an accident or illness affecting the Eligible Individual, to the extent the Eligible Individual recovers money from any third party as a result of such illness or injury.

Example: You enroll in the Plan and are covered by the Fee-for Service Options. You are in an accident with a third party and the Trust pays \$20,000 toward your medical care resulting from the accident. You hire a lawyer who sues the third party and recovers \$100,000. The lawyer charges \$25,000 plus there are costs of \$5,000, so the net recovery is \$70,000 ($\$100,000 - \$25,000 - \$5,000 = \$70,000$). The first \$20,000 of the \$70,000 net recovery belongs to the Trust and must be immediately paid to the Trust.

More specifically, when an person accepts Eligible Individual status under the Plan, such Eligible Individual agrees, on behalf of such Eligible Individual and any individual or entity claiming through such Eligible Individual (such as an heir, a beneficiary, a personal representative, the Eligible individual's estate, a trust, an assignee or any other person deriving rights from the Eligible Individual) (a "Payee"), that if any payments are received or receivable by or for the benefit of such Payee from any source whatsoever, which are, in whole or in part, to recompense the Payee for an injury or illness for expenses have been, or may be, paid by the Trust, (the "Gross Recovery") such Payee is obligated to repay the Trust, out of the first Gross Recovery proceeds payable, the amount paid by the Trust to, or on behalf of, the Payee under the Fee-for-Service Options for expenses arising from that injury or illness, up to the amount of the "Net Recovery." The Payee further agrees that the Trust shall have a security interest in the Net Proceeds and the right to receive them until the Trust's right to repayment is satisfied.

"Net Recovery" means the amount of the Gross Recovery reduced by the following expenses paid or payable in cash by, or on behalf of, the Payee, to the extent the Trust in its discretion determines them to be necessary to obtain the Gross Recovery, and reasonable in amount:

- attorney fees, not to exceed thirty percent of the Gross Recovery, required to obtain the Gross Recovery
- costs and expenses for medical care arising out of the illness or injury not otherwise payable by the Plan
- other costs and expenses paid by the Payee, required to obtain the Gross Recovery.

The Payee will be required to submit any and all documentation to the Administrative Office or Trust counsel that the Trust deems necessary to verify the calculation of the Net Proceeds.

Upon acceptance of the relevant Eligible Individual status, including by enrollment in the Plan, and as a condition thereto, the Payee agrees to the repayment right of the Trust as described above. In addition, if Trust counsel so requests, the Payee will be required to sign-supplemental contractual documents satisfactory to the Trust² further obligating the Payee to satisfy the Trust's reimbursement rights as described above and in such further specificity as such documents shall provide. If the Payee fails to sign these documents, or otherwise materially fails to fulfill the reimbursement obligation-described in the first sentence of this paragraph, the Eligible Individual status of the Payee and any other Eligible Individual whose status as such is conferred by, or derived from, the Payee, shall be terminated upon written notice from the Trust, and no reimbursements by or on behalf of such Payee shall be paid by the Trust thereafter respecting such former Eligible Individual pending satisfaction of the Trust's repayment right as described in this paragraph.

PRIVACY OF HEALTH INFORMATION

The Fund 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.

Copies of the Fund's Privacy Notice are 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 himself or herself 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.

CLAIMS REVIEW PROCEDURES

NOTE: The information provided here is applicable only to benefits and eligibility determinations under the Fee-For-Service health options and the Plan's life insurance and accidental death and dismemberment benefits. If you are covered under any HMO or DMO, it is not necessary to file a claim when their participating providers render services. Should you receive covered emergency services from a non-participating provider, the procedure to follow in filing a claim for benefits is described in the Disclosure Form/Evidence of Coverage booklets issued by the HMO or DMO dental plan. Those organizations also have their own review and appeals procedures, which are described in the Disclosure Form/Evidence of Coverage booklets.

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.

Types of Claims

There are five types of claims applicable to the benefits described in this booklet. Three of them have to do with health care benefits under the Fee-for-Service options:

- **Pre-service claims (applicable only to benefits that require pre-authorization):** A pre-service claim is a request for pre-authorization of a treatment, supply or service for which the Plan requires a showing that the treatment, supply or service is Medically Necessary before it is obtained.

If you fail to pre-authorize the following services your benefits may be denied:

- Partial hospitalization in connection with Psychiatric Care
- Hospice care
- Hospital and anesthesia services in connection with dental care
- The following prescription drugs: prescribed nutritional supplements, growth hormone, Interferon, Oxycontin, Oxycodone, Hydromorphone, Actiq

If you seek pre-authorization of any of these treatments, supplies or services, the Administrative Office or other medical review authority will review the proposed treatment, supply or service to determine whether it is Medically Necessary.

Voluntary pre-authorization is recommended for certain other services (such as surgical procedures where the surgeon's fee is expected to exceed \$1,500, MRIs and CAT scans, and dental treatment where the fees are expected to exceed \$500). See "Pre-Authorization" in Chapter 2 and the discussion of pre-authorization at the start of chapter 3 for more information.

NOTE: Urgent emergency care does NOT require pre-authorization. However, the amount payable for emergency care is subject to the Plan's limits and exclusions that are otherwise applicable.

- **Concurrent care decisions:** A concurrent care decision is a decision that is made after an initial approval was made and that may result in a reduction, termination or extension of a benefit. (An example of this would be partial hospitalization in connection with Psychiatric Care originally certified for 5 days that is reviewed at 3 days to determine if the full 5 days is appropriate.) In this situation a decision to reduce, terminate or extend treatment is made concurrently with the provision of treatment.
- **Post-service claims:** Any other type of health care claim is considered a post-service claim—for example, a claim submitted for payment after health services and treatment have been obtained.

The other two categories of benefit claims under this Plan are as follows:

- **Disability claims:** A disability claim is any claim that requires a finding of disability as a condition of eligibility. For example, a claim for benefits requiring a determination of disability for disability hours credit under the eligibility rules for active Carpenters will be treated as a disability claim. Another example is a claim for benefits requiring a determination of disability for weekly disability benefits provided to active Carpenters working outside California will be treated as a disability claim.
- **Other claims:** The category “other claims” includes claims for life insurance and accidental death and dismemberment benefits.

What is NOT a “Claim”

The following are not considered claims and are thus not subject to the requirements and timelines described in this section.

- Simple inquiries about the Plan’s provisions that are unrelated to any specific benefit claim will not be treated as a claim for benefits. For example, calling the Administrative Office and asking whether the Fund covers speech therapy is not a claim for benefits.
- A request for pre-authorization when pre-authorization is not required will not be treated as a claim for benefits. A request regarding the Plan’s coverage of a medical treatment, service or supply that your Physician has recommended is not a “claim” under these procedures unless the Plan requires you to obtain pre-authorization. For example, pre-authorization of an appendectomy is not a mandatory condition for receiving benefits, and a request for pre-authorization of an appendectomy will not be treated as a claim for benefits. See “Pre-Authorization” in Chapters 2 and 3 for discussions of the Plan’s pre-authorization requirements.
- A “claim” does not include an attempt to fill a prescription at a retail pharmacy. However, if your request for a prescription is denied, in whole or in part, you may file a claim by using the procedures described below.
- Requests for determination of whether a person is eligible for benefits will not be considered a claim under these procedures *unless a specific claim for benefits is denied for lack of eligibility.*

Filing a Claim

Unless otherwise indicated, in order to receive benefits, you must file a written claim with the Administrative Office or other location indicated below. 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 in “Pre-Authorization” in Chapters 2 and 3. 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 recapitulation of the information presented there:

- **Pre-service claims for health care benefits:** You or your provider may telephone (213) 385-0551 or (800) 252-9255 to request pre-authorization. Alternatively, you may complete a Pre-Authorization Request form (available from the Administrative Office) and send or hand-deliver the completed form to the Administrative Office at the following address:

Southwest Carpenters Health and Welfare Trust
533 South Fremont Avenue
Los Angeles, California 90071-1706

Or, for Nevada participants

Southwest Carpenters Health and Welfare Trust
980 Kelly Johnson Drive, Suite 180
Las Vegas, NV 89119

- **Post-service claims for medical and dental benefits:** Post-service claims for health care benefits other than vision or prescription drugs should be sent to the following address:

Southwest Carpenters Health and Welfare Trust
P.O. Box 17973
Los Angeles, California 90017-0973

- **Post-service claims for vision benefits:** Send your claim directly to Spectera at the following address:

Spectera
Attn: Claims Dept.
P.O. Box 26618
Baltimore, MD 21244-2644

You will need to submit a claim for vision benefits only if you use a non-participating provider.

- **Post-service claims for prescription drug benefits:**

Claim forms are not necessary if you use a contracting retail pharmacy. If you use a non-contracting pharmacy, contact the Administrative Office for details.

- **Claims for disability hours credit or weekly disability benefits:** In the event that you become disabled, notify the Administrative Office of this fact at once. The Administrative Office will let you know what information is required to establish the disabled status.
- **Life insurance or accidental death and dismemberment 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 either of the addresses shown for the Trust above.

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.

Using an 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 Administrative Office at least annually.

When Claims Must Be Filed

Your claim will be considered to have been filed as soon as it is received by the Administrative Office.

Pre-service claims must be filed **before services are obtained**. If you improperly file a pre-service claim, the Administrative Office 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.

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 shall 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 1 year from the date the charges were incurred.

Timing of Initial Claims Decisions

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

- **Pre-service claims:** If your pre-service claim has been properly filed, the Administrative Office (or a duly authorized agent of the Trust) 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 Administrative Office. 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 Administrative Office expects to make 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 **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 Administrative Office then has **15 days** to make a decision and notify you of the determination.

- **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 (other than by Plan amendment or termination) or the number of treatments, 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 Administrative Office 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 Administrative Office. 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 Administrative Office expects to make 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 **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 Administrative Office then has **15 days** to make a decision on your post-service claim and notify you of the determination.

- **Claims for disability hours credit or weekly disability 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 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 (Adverse Benefit Determinations)**

You will be provided with written notice of a denial of a claim, whether your claim is denied in whole or in part. This notice will include

- the specific reason(s) for the determination,
- reference to the specific Plan provision(s) on which the determination is based,
- a description of any additional material or information necessary if you want a further review of the claim and an explanation of why the material or information is necessary,
- a description of the appeal procedures and applicable time limits,
- a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review,

- 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, and
- 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.

For pre-service claims, you will receive notice of the determination orally or in writing even when the claim is approved.

Appeal of an Adverse Benefit Determination

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). Your request for review must be made in writing as follows:

- to the Administrative Office within **180 days** after you receive the notice of denial for a claim involving health care or disability (or, in the case of a concurrent care decision, within a reasonable time, given the medical exigencies of your situation)
- to Prudential within **60 days** after you receive the notice of denial for life insurance or accidental death and dismemberment claims
- **NOTE REGARDING DENIED PRESCRIPTION DRUG CLAIMS:** The Pharmacy Benefit Manager (PBM) will not be able to render a decision on any appeal regarding denial of a claim for prescription drug benefits-the Department of Labor claims regulations prohibit PBM from rendering a decision on appeal of a matter that it already reviewed. However, if the denial was due to lack of information or erroneous information, you or your Physician may submit the missing information informally to PBM (or indicate informally that the information was erroneous) after the initial denial which in some cases will resolve the issue. As long as such a submission or indication is not designated at part of the appeal of the initial denial, PBM will treat it as a second claim for benefits and will render a decision on the claim.

Review Process

The review process works as follows:

You have the right to submit comments, documents, records and other information in support of your claim for benefits. Upon request and free of charge, the Plan will provide you with reasonable access to and copies of all documents, records or other information relevant to your claim. A document, record or other information is relevant if it was relied upon in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon) in connection with the claim; it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision-making; or it constitutes a statement of Plan policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice on your claim, without regard to whether their advice was relied upon in deciding your claim.

A different person will review your claim than the one which originally denied the claim, and such person will not be a subordinate of the person who originally denied your claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the whole record, including such additional documents and comments that may be submitted by you relating to the claim.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary or was investigational or Experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. Such professional will not be an individual who was consulted in connection with the initial determination that is the subject of the appeal or any subordinate of such individual.

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 review within **30 days** of receipt of the appeal by the Administrative Office.
- **Concurrent care decisions:** You will receive notice of a decision on review **before reduction or termination** of a treatment in progress.
- **Post-service claims:** Ordinarily, decisions on appeals involving post-service claims will be made at the next regularly

scheduled quarterly **meeting** of the Health Care Committee of the Board 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 Health Care 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 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 disability hours credit or weekly disability benefits:** Timing and procedures for appeals involving disability claims are the same as those described immediately above for post-service health care claims.
- **Life insurance or accidental death and dismemberment claims:** Decisions will ordinarily be made within **60 days** of receipt of appeal by the Prudential. The period for making a decision may be extended by up to **60 days**, provided Prudential notifies you, prior to the expiration of the first 60 days, of the circumstances requiring the extension and the date as of which Prudential expects to render a decision.

The decision on any review of your claim will be given to you in writing. The notice of a denial of a claim on review will include:

- the specific reason(s) for the determination,
- reference to the specific Plan provision(s) on which the determination is based,
- a statement that you are entitled to receive reasonable access to and copies of all documents, records and other information relevant to your claim, upon request and free of charge,
- a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review,
- if an internal rule, guideline, protocol or similar criterion was relied upon, either a copy of the rule, guideline, protocol or similar criterion or a statement that it is available upon request at no charge,
- 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.

Limitation on When a Lawsuit May Be Started

You may not file a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review (or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision).

Maximum Times for Processing of Health Care Claims

(Times are suspended during waits for additional information requested of you)

| | Pre-Service Claims | Concurrent Care Decisions | Post-Service Claims |
|--|---|---|---|
| Administrative Office makes initial determination (provided all necessary information is submitted) | Within 15 days of claim's receipt (can be extended for another 15 days) | In time for you to appeal before a reduction or termination | Within 30 days of claim's receipt (can be extended for another 15 days) |
| Administrative Office notifies you claim has been improperly filed | Within 5 days of claim's receipt | Not applicable | Not applicable |
| Administrative Office requests additional information | Within 15 days of claim's receipt | Not applicable | Within 30 days of claim's receipt |
| You respond to request for information | Within 45 days of request | Not applicable | Within 45 days of request |
| Administrative Office makes determination after requesting information | Within 15 days of your response or expiration of the time allowed | Not applicable | Within 15 days of your response or expiration of the time allowed |
| You make request for appeal | Within 180 days of receiving notice of denial | Within a reasonable time for your situation | Within 180 days of receiving notice of denial |
| Administrative Office/Board Committee makes decision on appeal | Within 30 days of receiving your request for appeal | Within a reasonable time for type of care decision | At next regular quarterly Committee meeting or, if appeal is received less than 30 days in advance, at subsequent meeting (may be delayed until third such meeting) |

Maximum Times for Processing of Disability and Life Insurance or Accidental Death and Dismemberment Claims

(Times are suspended during waits for 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 (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 |
| Administrative Office/insurance company makes determination after requesting additional information | Within 30 days of your response or expiration of the time allowed | Not applicable |
| You make request for appeal | Within 180 days of receiving notice of denial | Within 60 days of receiving notice of denial |
| Board Committee/insurance company makes decision on appeal | At next regular Board Committee meeting at least 30 days after receiving your request for appeal (or no later than third such meeting) | Within 60 days of receipt of your request for appeal (can be extended another 60 days) |

FACTORS THAT COULD AFFECT YOUR RECEIPT OF BENEFITS

Many of the points below specifically reference the Fee-for-Service Medical Option. If you are in one of the HMOs or DMO dental options, see the benefit booklet and any other materials provided by that organization 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 1.
- **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 1 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 or enrollment form is submitted to the Administrative Office. See Chapter 1 and the Chapters on the health care benefits for more information.

- **Failure to follow the Plan’s provisions for pre-authorization.** If you are enrolled in the Fee-for-Service health care plans and you wish to receive the maximum benefits available, you must comply with the Plan’s pre-authorization requirements for partial hospitalization in connection with Psychiatric Care, hospice care, Hospital and anesthesia services in connection with dental care and certain prescription drugs. See “Pre-Authorization” in Chapter 2 and Chapter 3 for more information.
- **Failure to use contracting providers.** If you are enrolled in the Fee-for-Service medical, prescription drug or vision care 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 2, 3, and 4 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 1 of this booklet.
- **Failure to submit claims in a timely way.** You should submit all Fee-for-Service health care claims and appeals and required information **within the time frames described in “Claims Review Procedures” set forth earlier in this Chapter.**
- **The Plan’s provisions for coordination of health care benefits.** If you or a Dependent has medical, vision care or dental coverage under another plan, payment of benefits under any of the Fee-for-Service options will be coordinated with payment of benefits by that other plan. See “Coordination of Benefits and Reimbursement Obligation” earlier in this Chapter 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 not be available to reimburse the Plan. See “Coordination of Benefits and Reimbursement Obligation” earlier in this Chapter and the “General Limitations and Exclusions Summary” later in this Chapter for more information.
- **Failure to update your address or enrollment cards.** If you move, it is your responsibility to keep the Administrative Office informed about where it 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. You will be held liable for benefit payments 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. *See also Chapter 1 for information on maintaining eligibility for benefits.*

GENERAL LIMITATIONS AND EXCLUSIONS SUMMARY

NOTE: The following list of limitations and exclusions applies to the Fee-for-Service Options. If you are in one of the HMOs or DMO dental plans, please refer to the benefit booklet(s) for that HMO or dental plan for information on the limitations and exclusions applicable to your option.

All of the Plan’s Fee-For-Service Option benefits are subject to the following limitations and exclusions in addition to those outlined under each benefit description.

No benefits will be provided for:

- 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
- occupational injuries or sicknesses
- conditions caused by or arising out of an act of war, armed invasion or aggression
- any supplies or services
 - for which no charge is made, or
 - for which the individual is not required to pay in the absence of this Plan, or

- 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, or
- which are provided as part of court-ordered care
- any benefit that would otherwise be available, if the Trust is entitled to reimbursement for that benefit, and if those who are obligated to perform acts to accomplish that reimbursement fail to do so, but only as to the benefits to which the reimbursement obligation applies
- any benefit that would otherwise 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
- services received by an Eligible Individual which are performed by the spouse, child, brother, sister or parent of the Eligible Individual or the Eligible Individual's spouse
- any services or procedures which are Experimental or are not within the standards of generally accepted medical or dental practice
- bone marrow transplant, or removal and replacement, in connection with high-dose chemotherapy treatment for breast cancer
- care or treatment in any penal institution or jail facility or jail ward of any State or political subdivision
- any care or treatment performed by a provider not specifically covered under the Plan, regardless of whether or not the provider is licensed to perform such treatment, including, but not limited to, a marriage, family and child counselor
- organ transplants, including bone marrow transplants or bone marrow removal and replacement, except the following:
 - kidney transplants,
 - liver transplants (in cases of congenital biliary atresia only),
 - transplants of cornea, skin, bone, tendons and bone marrow if the diagnosis is non-intentionally induced severe aplastic anemia or acute leukemia,
 - transplants of artificial organ parts-limited only to joint replacement for functional reasons, skin, heart valves, grafts and patches (vascular), pacemaker, metal plates and eye lens

The organ recipient for a covered transplant must be an eligible individual under this Plan in order for benefits to be available for an organ donor
- any services or supplies related to temporomandibular joint dysfunction, including surgery performed on the temporomandibular joint
- 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, with the exception of services and supplies for the diagnosis of infertility
- 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 her medical expenses for pregnancy are being paid by another individual or entity;
- 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 psychiatric treatment or study related to sex change)
- any surgical procedure or any other treatment, service or supply in connection with weight reduction, gain or control regardless of whether or not a diagnosis of morbid obesity exists
- any surgical procedure or other treatment for complications of a procedure which is excluded under the Plan
- services, supplies or treatments which are not Medically Necessary except as specifically provided otherwise in the Plan
- any charges that are in excess of Allowable Charges as defined in the Glossary or are in excess of a specific Plan limit on Allowable Charges as provided in Chapter 2
- Alopecia (loss of hair)

- Custodial Care except as specifically provided under the Medical Plan’s hospice care benefits. (*Be aware that the term “Custodial Care” has a special meaning—refer to the glossary at the end of this booklet. Among other things, care that simply maintains a person’s condition or makes him more comfortable may be considered Custodial Care and not covered.*)
- 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
- 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.)
- Recreational therapy, educational therapy, occupational therapy or forms of non-medical, self-care or self-help training, and any related diagnostic testing
- Care or treatment of injuries resulting from an Eligible Individual’s commission of, or attempt to commit, an assault, or felony
- Services rendered through the internet, fax, telephone, video or by any other electronic means.

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 Administrative Office for reimbursement. An itemized billing is required for any claim incurred outside the United States.

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 Plan Document with amendments and updated Summary Plan Description. 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 1 of this SPD booklet, or HMO booklets, for the rules governing your COBRA continuation coverage rights (and in the case of HMO coverage, Cal-COBRA rights).
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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.

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 INFORMATION

Determining Documents

If you are eligible under the Plan, your rights will be determined by

- the Plan Document entitled “Southwest Carpenters Health and Welfare Plan for Active Carpenters Restated January 1, 2005” relating to all eligibility requirements and benefits provided by the Fee-For-Service medical, prescription drug, and dental plans and weekly disability benefits provided by the Trust
- the Kaiser Service Agreement relating to the hospital, medical, prescription drug and vision benefits provided by Kaiser
- the PacifiCare Agreements relating to the hospital, medical and prescription drug benefits provided by PacifiCare
- Hometown Health Agreements relating to the hospital, medical and prescription drug benefits provided by Hometown Health
- Health Plan of Nevada Agreements relating to the hospital, medical and prescription drug benefits provided by Health Plan of Nevada
- Intermountain Health Care Agreements relating to the hospital, medical and prescription drug benefits provided by IHC Plans
- the Pacific Union Dental Agreement relating to the dental benefits provided by Pacific Union Dental, Nevada Pacific Dental and Total Dental Administrators
- the Golden West Agreements relating to the dental benefits provided by Golden West and Employers Dental Services
- The Prudential Policy with respect to the life insurance and accidental death and dismemberment benefits
- The Spectera Agreement relating to the vision care benefits provided by Spectera.

The information contained in this booklet is intended to be a summary of the Plan document’s eligibility rules and benefits. In the event of any conflict between the provisions contained in this summary booklet and the Plan Document, the provisions of the Plan Document shall prevail.

Additionally, in the event of any conflict between the provisions contained in the Plan Document and any other agreement with a service provider, the provisions contained in the Plan Document shall prevail.

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, Plan Document, this Summary Plan Description 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 shall 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 “Claims Review Procedures” earlier in this chapter 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, DMO or similar organization, any dispute as to eligibility, type, amount, or duration of benefits shall 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 Fee-for-Service medical, Fee-for-Service dental, Fee-for-Service prescription drug, and weekly 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 shall 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 shall be liable solely and exclusively for health and welfare benefits due under its own plan, and no fund shall 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.

PLAN FACTS

| | |
|--------------------------------|---|
| Name of Plan | Southwest Carpenters Health and Welfare Plan for Active Carpenters |
| Type of Plan | Employee welfare benefit plan maintained for the purpose of providing life insurance, accidental death and dismemberment insurance, weekly disability, hospital, medical, prescription drug, dental and vision 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. |
| 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. The Collective Bargaining Agreements require contributions to this Plan at a fixed rate per hour worked.</p> <p>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.</p> <p>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 | 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. |
| Employer Identification Number (EIN) | The number assigned to the Plan by the Internal Revenue Service is 95-6042873. |
| Plan Administrator | <p>The Board of Trustees Southwest Carpenters Health and Welfare Trust 533 South Fremont Avenue Los Angeles, CA 90071-1706 Telephone: (213) 386-8590</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 & Connor P.C. 533 South Fremont Avenue 9th Floor Los Angeles, CA 90071-1706</p> <p>or</p> <p>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</p> <p>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 which 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 and claims processing functions of the Plan are performed by:

Carpenters Southwest Administrative Corporation
533 South Fremont Avenue
Los Angeles, CA 90071-1706
Telephone (213) 386-8590
(800) 293-1370

Trustees

The names and addresses of the Trustees as of the date of this booklet are as follows:

Employee Trustees

Employer Trustees

| | |
|--|--|
| <p>Mr. Tom Benson Controller Southwest Regional Council of Carpenters 533 South Fremont Avenue 10th Floor Los Angeles, CA 90071</p> | <p>Curtis Conyers, Jr. Richard Lane Company 419 West Maple Ave. Monrovia, CA 91016</p> |
| <p>Mr. James K. Bernsen 11322 Kensington Road Los Alamitos, CA 90720</p> | <p>Mr. Kim Fromer President Fromer, Inc. 22225 Acorn Street Chatsworth, CA 91311</p> |
| <p>Floyd Clay Senior Administrative Assistant Southwest Regional Council of Carpenters 533 South Fremont Avenue Los Angeles, CA 90071</p> | <p>Mr. Richard Harris Wesseln Construction Co., Inc. 292 North Wilshire Avenue Ste. 103 Anaheim, CA 92801-5851</p> |
| <p>Mr. Gordon K. Hubel Contract Administrator Southwest Regional Council of Carpenters 533 South Fremont Avenue Suite 411 Los Angeles, CA 90071</p> | <p>Mr. Gary Jaacks Raymond Interior Systems 520 West Walnut Avenue Orange, CA 92868</p> |
| <p>Mr. Douglas J. McCarron United Brotherhood of Carpenters & Joiners of America 101 Constitution Avenue NW 10th Floor Washington, DC 20001</p> | <p>Mr. Ralph Larison Connolly-Pacific Company 1925 Pier D Street Long Beach, CA 90802</p> |
| <p>Mr. Mike McCarron Secretary/Treasurer Southwest Regional Council of Carpenters 533 South Fremont Avenue Los Angeles, CA 90071</p> | <p>Mr. Bert Lewitt Morley Construction Co. 2901 28th Street Santa Monica, CA 90405</p> |
| <p>Mr. Armando Vegara Administrative Assistant Southwest Regional Council of Carpenters 533 South Fremont Avenue 10th Floor Los Angeles, CA 90071</p> | <p>Mr. Ronald N. Tutor Tutor-Saliba Corp. 15901 Olden Street Sylmar, CA 91342</p> |
| <p>Marc Furman Senior Administrative Assistant Southwest Regional Council of Carpenters 501 N. Lamb 2nd Floor Las Vegas, NV 89110</p> | <p>Perry Eiman Marnell Corrao Associates 22 Via Marnell Way Las Vegas, NV 89119</p> |

Identity of Providers of Benefits

Benefits are provided directly by the Trust for the Fee-For-Service medical, prescription drug, dental and weekly disability benefits described in this booklet.

HMO medical, prescription drug and vision care benefits are provided through Kaiser and HMO medical and prescription drug benefits are provided through PacifiCare, Hometown Health and Health Plan of Nevada and IHC Plans.

DMO dental benefits are provided through Golden West and Pacific Union Dental

Vision care benefits (other than those provided by Kaiser) are provided through Spectera.

The life insurance and accidental death and dismemberment benefits are underwritten by Prudential.

The complete terms of the self-funded benefits are set forth in the Trust's Plan Document. The complete terms of the HMO/DMO benefits are set forth in the service agreements with Kaiser, PacifiCare, Hometown Health, Health Plan of Nevada, IHC, Pacific Union Dental and Golden West. The complete terms of the insured benefits are set forth in the group insurance policies with Prudential and Spectera. (*See also "Determining Documents" under "General Plan Information" earlier in this chapter.*)

Following are the names and addresses of the organizations through which benefits or services are provided or administered:

Blue Cross

21555 Oxnard St., 11A
Woodland Hills, CA 91367

(Preferred Provider Organization inside California for the Fee-for-Service Medical Plan)

CCN

10260 Meanley Drive
San Diego, CA 92131

(Preferred Provider Organization inside Arizona for the Fee-for-Service Medical Plan)

Beech Street

25500 Commercentre Dr.
Lake Forest, CA 92630

(Preferred Provider Organization for all other areas for the Fee-for-Service Medical Plan)

Kaiser Permanente

393 E. Walnut
Pasadena, CA 91188-8530
(HMO)

PacifiCare of California

5816 Corporate Ave., Ste 190
Mail Stop CY46-144
Cypress, CA 90630
(HMO)

PacifiCare of Arizona, Inc.

410 N. 44th Street, 10th Floor
M/S AZ70-025
Phoenix, AZ 85008
(HMO)

Health Plan of Nevada

2700 N. Tenaya Way
Las Vegas, NV 89128
(HMO)

Hometown Health

830 Harvard Way
Reno, NV 89502
(HMO)

IHC Health Plans

4646 Lake Park Blvd.
Salt Lake City, UT 84120
(HMO)

Spectera

100 Corporate Pointe, Suite 380
Culver City, CA 90230
(Vision care plan insurer)

Pacific Union Dental

1390 Willow Pass Road, Suite 800
Concord, CA 94520-5240
(DMO dental plan)

Golden West Dental

888 West Ventura Blvd.
Camarillo, CA 93010
(DMO dental plan)

Prudential

15301 Ventura Boulevard, Suite 420
Sherman Oaks, CA 91403
(Provider of fully insured life insurance and accidental death and dismemberment coverage)

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 and retired 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, shall 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.

GLOSSARY OF TERMS USED IN THIS BOOKLET

Capitalized terms used in this booklet have a precise meaning. Below are some of the definitions.

ADMINISTRATIVE OFFICE

“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. Another Administrative Office is located at 980 Kelly Johnson Drive, Suite 180, Las Vegas, Nevada 89119, (702) 851-4510 or (800) 501-0210 and there are satellite offices at 4547 W. McDowell Rd., Phoenix, AZ 85035-4121, (602) 352-6805 and 8149 S. Welby Park Dr., West Jordan, UT 84088, (801) 282-6528 that are focused upon the needs of participants working in those areas.

ALLOWABLE CHARGE

“Allowable Charge” means the customary charge for a service or supply covered by the Plan, if incurred (within the meaning of the last sentence of this definition) with respect to an Eligible Individual while the individual is in that status, but not exceeding such charge as would have been made in the absence of benefits provided under this Plan.

A “customary charge,” as used herein, means:

- For non-PPO providers – the usual charge made by a Physician, Hospital, Extended Care Facility, Dentist or other health care professional or firm having rendered or furnished services, treatments or supplies for bodily injuries and sicknesses which do not exceed the general level of charges made by others rendering or furnishing such services, treatments or supplies within the area in which the charge is incurred for bodily injuries or sicknesses comparable in severity and nature to the bodily injuries or sicknesses treated or being treated; with respect to services, treatments or supplies listed in usual and customary charge data reported by Ingenix, the “general level of charges” referred to above shall be determined based on the 70th percentile of such charge data reported by Ingenix or
- For PPO providers - the applicable PPO contracted fee for the service, treatment or supply within the area in which the charge is incurred.

The term “area,” as it would apply to any particular item for which an Allowable Charge may be incurred, means a county or such greater area as is necessary to obtain a representative cross-section of entities furnishing such items.

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.

AMBULATORY CENTER

“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.

| | |
|---------------------------------|---|
| CERTIFIED NURSE-MIDWIFE | <p>“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.</p> |
| COLLECTIVE BARGAINING AGREEMENT | <p>“Collective Bargaining Agreement” means</p> <ul style="list-style-type: none"> • 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 | <p>“Contributing Employer” means</p> <ul style="list-style-type: none"> • 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 employees described in Article II, Section 1(c) of the Plan Document. |
| CUSTODIAL CARE | <p>“Custodial Care” means care rendered to an Eligible Individual who</p> <ul style="list-style-type: none"> • is disabled mentally or physically (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 psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored or controlled environment. <p>This specific definition is found in the federal Dependents’ Medical Care Act, and in regulations implementing that Act and the definition of Custodial Care. These authorities provide further guidance as to the meaning of Custodial Care for Plan purposes.</p> |
| DENTIST | <p>“Dentist” means a Dentist licensed to practice Dentistry in the State in which he renders treatment.</p> |
| DEPENDENT | <p>“Dependent” means an active Carpenter’s or Special Class Employee’s</p> <ul style="list-style-type: none"> • lawful spouse (a spouse that is legally separated from the active Carpenter or Special Class Employee is not eligible), • unmarried natural child, stepchild, legally adopted child, foster child, or child placed for adoption, <ul style="list-style-type: none"> (i) from birth up to his/her 19th birthday, (ii) from age 19 to his/her 23rd birthday if they are a full time student in an accredited institution of learning, (iii) 19 years of age or older and 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 months, <i>provided the following conditions are met:</i> |

1. The child does not provide the majority of his or her own support in the calendar year.
2. With respect to children described in clauses (i), (ii) and (iii) above, the child's official principal place of adobe is at the active Carpenter's or Special Class Employee's primary residence more than half the calendar year **or**, *if the active Carpenter or Special Class Employee is divorced or legally separated from the child's other parent under a decree of divorce or separate maintenance, or is separated pursuant to a written separation agreement, or lives apart from such other parent at all times during the last six months of the calendar year*, the child receives over one-half of his or her support during the calendar year from his or her parents, and the child is in the custody of one or both of his or her parents more than one half the calendar year.
4. In the case of a child described in clause (iii), pertaining to a disabled child 19 years of age or older, if the requirements of subsection 2 are not met, they will be deemed met if over one half of the child's support in the calendar year is provided by the active Carpenter or Special Class Employee.

The terms "legally adopted child" and "foster child" shall mean and include any person who otherwise meets the age requirements specified above in this definition who is, or once was, a legally adopted child or foster child by virtue of a court order specifying that the active Carpenter or Special Class Employee has, or had, legal responsibility for custody and maintenance of the child, provided the child primarily resides, or did reside, prior to full-time student or missionary status, with the active Carpenter or Special Class Employee in a regular parent-child relationship.

The term "child placed 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.

"Dependent" does not include any person who becomes an Eligible Individual for any reason other than being a Dependent as defined here. If a Dependent may claim that status by reason of a relationship to more than one active Carpenter or Special Class Employee, the Dependent shall 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 referred to in Article II, Section 3 of the Plan Document).

Parents or siblings of active Carpenters or Special Class Employees or of the spouse of such Eligible Individuals are not Dependents under this Plan in any circumstance.

DMO "DMO" means a "dental maintenance organization" that contracts with the Trust to provide certain dental services for a flat fee to the Trust, which is offered as a dental care option under the Plan.

ELIGIBLE INDIVIDUAL "Eligible Individual" means an active Carpenter, Special Class Employee, Dependent, COBRA participant, eligible Uniformed Services participant on military duty and electing Plan coverage, or QMCSO Beneficiary, who is entitled to Plan benefits by reason of meeting the eligibility requirements summarized in Chapter 1 of this booklet and specified in the Plan Document.

EMERGENCY "Emergency" means a sudden unexpected onset of a medical condition, not normally treatable in the provider's office, that manifests itself by acute symptoms of enough severity that urgent and immediate medical attention is required without regard to the hour of day or night to prevent significant impairment in bodily functions or serious and/or permanent damage to any bodily organ or part.

EXPERIMENTAL "Experimental" means any procedure, treatment, therapy, drug, biological product, facility, equipment, device or supply which the Board or its Delegate has determined, in its sole discretion, not to have been demonstrated as safe and effective as compared with the standard means of treatment or diagnosis. "Experimental" also means any procedure, treatment, therapy, drug, biological product, facility, equipment, device or supply that is determined by the Board or its Delegate to be investigational, educational or the subject of current clinical trials.

In making a determination under this definition, the Board or its Delegate shall refer to reliable evidence, which may be derived, without limitation, from one or more of the following sources:

- published, authoritative peer-reviewed medical and scientific literature regarding the procedure at issue as applied to the injury or illness at issue,
- publications and evaluations from national medical associations, such as the American Medical Association or specialty medical associations,
- regulations and other official guidelines or publications issued by the U.S. Food and Drug Administration (FDA) or Department of Health and Human Services, and
- written protocols and consent forms used by the treating facility or by another facility administering substantially the same drug, device or medical treatment.

For the Board or its Delegate to determine that the service or supply is safe and effective as compared with the standard means of treatment or diagnosis, the service or supply must meet all of the following applicable criteria:

- reliable evidence must conclusively show that the service or supply is recognized as approved, in accordance with generally accepted standards in the national medical community, as being safe and effective for use in the treatment or diagnosis of the illness, injury or condition at issue,
- any required approval of any Federal government or agency, or any State government or agency, must have been obtained prior to the time of use,
- if it is a drug or device that cannot be lawfully marketed without the approval of the FDA, final approval must have been obtained at the time the drug or device is furnished. Interim FDA approvals for a Phase I, II or III trial, pre-market approval applications and investigational exemptions are not sufficient. If final FDA approval has been obtained, only the uses and indications for which the drug or device was licensed are Allowable Charges.

Notwithstanding the foregoing, a service or supply shall be considered Experimental

- if the service or supply is provided pursuant to a Phase I or Phase II clinical trial or as the Experimental or research arm of a Phase III clinical trial,
- if it is under study to determine maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis or
- if its safety or efficacy or efficacy as compared with the standard means of treatment or diagnosis is the subject of substantial debate within the national medical community.

The fact that a Physician or other medical professional or expert may prescribe, order, recommend, recognize or approve any procedure, treatment, therapy, drug, biological product, facility, equipment, device or supply does not in itself make the service or supply non-Experimental within the meaning of this definition. Similarly, the fact that the service or supply is authorized by law or otherwise for use in testing, trials or other studies on human patients shall not in itself make the service or supply non-Experimental within this definition.

EXTENDED CARE FACILITY

“Extended Care 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 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.

| | |
|---|---|
| FEE-FOR-SERVICE MEDICAL OPTION | <p>“Fee-for-Service Medical Option” is the health care indemnity coverage provided directly by the Trust and described in detail in this booklet (Chapter 2) which you can choose, if eligible, as a medical care option under the Plan.</p> |
| FEE-FOR-SERVICE PRESCRIPTION DRUG BENEFIT | <p>“Fee-for-Service Prescription Drug Benefit” is the prescription drug indemnity coverage provided directly by the Trust through a contract with a pharmacy benefit manager and described in detail in this booklet (Chapter 3) which is part of the Fee-for -Service Medical Option.</p> |
| FEE-FOR-SERVICE (SPECTRA) VISION CARE | <p>“Fee-for-Service Vision Care Option” is the vision care indemnity coverage provided by Spectra and described in detail in this booklet (Chapter 4).</p> |
| FEE-FOR-SERVICE DENTAL OPTION | <p>“Fee-for-Service Dental Option” is the dental care indemnity coverage provided directly by the Trust and described in detail in this booklet (Chapter 5) which you can choose, if eligible, as a dental care option under the Plan.</p> |
| FEE-FOR-SERVICE OPTIONS | <p>“Fee-for-Service Options” means the Fee-for-Service Medical Option (which encompasses the Fee-for-Service Prescription Drug Benefit), and the Fee-for-Service Dental Option.</p> |
| FORMULARY | <p>“Formulary” means the list of preferred medications adopted by the Plan that includes drugs that are safe, clinically effective, and economical. The Plan has adopted as its Formulary under the Fee-for-Service Prescription Drug benefit, a list of medications formulated by its pharmacy benefit manager.</p> |
| HMO | <p>“HMO” means a “health maintenance organization” that contracts with the Trust to provide most medical services for a flat fee to the Trust, which you can choose, if eligible, as a medical care option under the Plan.</p> |
| HOME HEALTH CARE AGENCY | <p>“Home Health Care Agency” means an organization or agency that meets the requirements for participation as a “Home Health Care Agency” under Medicare.</p> |
| HOSPITAL | <p>“Hospital” means an institution that is:</p> <ul style="list-style-type: none"> • legally operating as a Hospital which (1) is primarily engaged in providing, for compensation from its patients, in-patient 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 • a State-licensed acute psychiatric Hospital or a psychiatric health facility operating pursuant to licensure by the state in which it is located 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. |
| MEDICALLY NECESSARY | <p>“Medically Necessary” means, when applied to a service or supply,</p> <ul style="list-style-type: none"> • a medical services 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 psychiatric service or supply which is reasonably necessary to provide Psychiatric Care. <p>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 shall be made by the Board or its Delegate solely and absolutely “in the sole and absolute discretion” of the Board or the Delegate as those terms are defined in the Plan Document.</p> |

| | |
|--------------------------------|--|
| PHYSICIAN | <p>“Physician” means a legally qualified physician (M.D.) or a State-licensed physician assistant when under the direct supervision of a physician (M.D.), when acting within the scope of his license.</p> |
| PLAN | <p>“Plan” means the Southwest Carpenters Health and Welfare Plan for Active Carpenters Restated January 1, 2005.</p> |
| PPO | <p>“PPO” means a “preferred provider organization” which contracts with the Trust to provide favorable prices for services under the under the Fee-For-Service Medical Option.</p> |
| PSYCHIATRIC CARE | <p>“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 (Third Edition — Revised) 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.</p> |
| PSYCHIATRIC TREATMENT FACILITY | <p>“Psychiatric Treatment Facility” as it applies to the treatment of a nervous or mental condition means a Hospital or an institution, or a distinct part of a Hospital, which meets all of the following requirements:</p> <ul style="list-style-type: none"> • 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. • 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. • 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. • 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. • 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. • It meets any applicable licensing standards established by the jurisdiction in which it is located. • It continuously provides skilled nursing services under the direction of a full-time Registered Nurse, with licensed nursing personnel on duty at all times. |
| REGISTERED NURSE | <p>“Registered Nurse” means a registered graduate nurse who is licensed as a registered nurse by the state where services are rendered.</p> |
| REHABILITATION FACILITY | <p>“Rehabilitation Facility” means an institution which is primarily engaged in providing inpatients with physical therapy services for the rehabilitation of injured, disabled or sick persons, and which meets all of the following requirements:</p> <ul style="list-style-type: none"> • it is regularly engaged in providing physical therapy and other rehabilitative services 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, • 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, |

- 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 is licensed in the state where it is located and is acting within the scope of its license

SPECIAL CLASS EMPLOYEE **“Special Class Employee”** means an employee of an employer that is related to the 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 1 for further information on the different Plan eligibility rules that apply to Special Class Employees.

SUBSTANCE ABUSE **“Substance Abuse”** means alcoholism, drug addiction or drug abuse.

SUBSTANCE ABUSE TREATMENT CENTER **“Substance Abuse Treatment Center”** means a facility licensed by the state in which it practices as a Chemical Dependency Recovery Hospital. This term shall 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.

TOTALLY DISABLED **“Totally Disabled”** means as a result of bodily injury or sickness, the complete inability to engage in any gainful occupation for which the disabled person is reasonably qualified by reason of education, training or experience and that he is not engaged in any gainful occupation. Notwithstanding the foregoing, the term “Totally Disabled” means, with respect to a Dependent, that as a result of bodily injury or sickness, the Dependent is unable to engage in his or her regular and customary activities and is not engaged in any employment or occupation for wage or profit.

TRUST **“Trust”** means the Southwest Carpenters Health and Welfare Trust.

UNIFORMED SERVICES **“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 **“Union”** means the Southwest Regional Council of Carpenters and any local union affiliate thereof.