CARPENTERS SOUTHWEST ADMINISTRATIVE CORPORATION

533 South Fremont Avenue
Los Angeles, CA 90071-1706

Tel: 213-386-8590 • **Toll Free:** 800-293-1370
www.carpenterssw.org

To: **All Participants and their Dependents Who Are Eligible for Bronze Health and Welfare Plan Benefits, including COBRA Beneficiaries**

Summary of Material Modifications
January 2022

PARTICIPANT NOTICE

This Participant Notice will advise you of certain material modifications (plan changes) that have been made to the Southwest Carpenters Health and Welfare Trust (the Plan). This information is **very important** for you and your eligible dependents. Please take the time to read it carefully.

Aviso a los participantes que hablan español: Si tiene alguna pregunta referente a este aviso o requiere alguna otra información referente a su cobertura de salud, por favor de comunicarse con la oficina administrativa al (213) 386-8590 o (800) 293-1370, donde habrá varios representantes bilingües que le ayudarán.

ANTHEM MEDICAL PPO PLAN CHANGES EFFECTIVE JANUARY 1, 2022

The Trustees are pleased to announce changes to Anthem Medical PPO benefits under the Southwest Carpenters Active Plan. **A summary of changes effective for services received on or after January 1, 2022 include:**

- **Coordination of Benefits:** The Plan will now allow coordination of benefits for families if both the employee and spouse are eligible and enrolled participants of the SWC Health plan and elect family coverage. When both spouses elect family coverage, each spouse and all covered children will be considered Dependents for each employee. In the past, if you and your spouse were both eligible for coverage as employees, the Plan did not allow you to claim each other as a Dependent and, if you have children, the children were only allowed to be covered as Dependents of one parent. This change will allow you to be reimbursed for up to 100% of Allowed Charges.

  If your family is eligible for this dual coverage within the SWC Health plan each employee should submit new enrollment forms listing your eligible spouse and other dependents. Once your family is properly enrolled, please contact Anthem as soon as possible to ensure your files are set up properly for the coordination of benefits before any claims are submitted.

- **Gender Dysphoria:** Effective January 1, 2022, the Plan will cover medically necessary services for the treatment of gender dysphoria including, but not limited to: psychotherapy, hormone replacement therapy, laboratory testing to monitor hormone therapy and gender reassignment surgery. These will be covered at the Plan's regular cost-sharing depending on type/location of services, and subject to the Plan's requirements, terms and limitations, including any preauthorization requirements. The Plan will continue to exclude any treatment for cosmetic reasons. Contact Anthem for coverage details.

- **Day Limits:** The Plan has various day limits on benefits as outlined below. Your mental health is a priority and in order to ensure you receive the services necessary, the day limits outlined for the services below **will not apply to treatment of diagnosed mental health conditions or substance use disorders consistent with generally recognized independent standards of current medical practice** (effective for services on or after January 1, 2022)**.**
    - **Marriage counseling**: 12 visits per person per calendar year and not more than one visit per day.
    - **Psychometric testing:** 8 hours per disability;
    - **Biofeedback services:** 4 visits per disability;
    - **Hospice benefits:** 180 days per lifetime;
    - **Inpatient Rehabilitation Services:** 30 days per calendar year;
    - **Physical Therapy:** 20 sessions per calendar year;
    - **Occupational Therapy:** 20 sessions per calendar year;
    - **Speech Therapy:**130 sessions per lifetime; and not more than one visit is covered per day.
    - **Skilled Nursing Facility confinement or Subacute care facility confinement:** 180 days per period of confinement.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"**Out-of-network**" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"**Surprise billing**" is an unexpected balance bill. This can happen when you cannot control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

- **Emergency services**

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **cannot** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

- **Certain services at an in-network hospital or ambulatory surgical center**

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **cannot** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **cannot** balance bill you, unless you give written consent and give up your protections.

You are <u>never</u> required to give up your protections from balance billing, so it's important you read information your provider is asking you to sign. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

<u>When balance billing isn't allowed, you also have the following protections:</u>

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact Anthem at (833) 224-6930.

Independent External Review

The Plan's existing appeals procedures include the right to seek an independent external review of an adverse benefit determination that involves medical judgment or a rescission of coverage. Effective with the plan year beginning on January 1, 2022, the right to independent external review also applies to adverse determinations with respect to:

- out-of-network emergency services;
- nonemergency services performed by nonparticipating providers at participating facilities; and
- air ambulance services furnished by nonparticipating providers of air ambulance services.

For example, a patient could ask for external review if the Plan decided that pre-stabilization emergency treatment in an out-of-network emergency room did not qualify as "emergency services" under the No Surprises Act and thus imposed greater cost sharing on the patient.

External reviews are initiated by contacting Anthem at (833) 224-6930.

For more information about your rights under federal law you can call the EBSA toll-free at (866) 444-EBSA (3272) or write 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 find answers to your Plan questions and a list of EBSA field offices at the website of EBSA at http://www.dol.gov/ebsa.

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If you have any questions about this notice, visit the Trust's website at **www.carpenterssw.org**. Or, contact the Administrative Office at (800) 293-1370 or (213) 386-8590.

Sincerely,

THE BOARD OF TRUSTEES

In accordance with ERISA reporting requirements, this document serves as your Summary of Material Modifications (SMM) to the Plan and we are advising you of these Plan changes within 60 days of the adoption of the Plan changes. Receipt of this notice does not constitute a determination of your eligibility. If you wish to verify eligibility, or if you have any questions regarding these Plan changes, contact the Administrative Office.

The 2022 Summary of Benefits and Coverage (SBC) is available at carpenterssw.org to help you understand what the Health Plan covers and what you pay for covered services. You may also request a paper copy to be mailed to you by contacting the Administrative Office.

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To: **All Participants and their Dependents Who Are Eligible for Active Health and Welfare Bronze Medical Plan Benefits, including COBRA Beneficiaries**

Summary of Material Modifications

June, 2021

PARTICIPANT NOTICE

This Participant notice will advise you of certain material modifications (plan changes) that will be made to the Southwest Carpenters Health and Welfare Trust (the Plan). This information is **very important** for you and your eligible dependents. Please take the time to read it carefully.

Aviso a los participantes que hablan español: Si tiene alguna pregunta referente a este aviso o requiere alguna otra información referente a su cobertura de salud, por favor de comunicarse con la oficina administrativa al (213) 386-8590 o (800) 293-1370, donde habrá varios representantes bilingües que le ayudarán.

New ComPsych Carpenters Assistance Program (CCAP) Effective January 1, 2021

The Board of Trustees is pleased to announce a new benefit effective for the 2021 plan year available to all eligible employees and their family members, regardless of whether you're enrolled in group health benefits through the Fund, the ComPsych Carpenters Assistance Program. ComPsych provides professional confidential counseling services for up to 5 visits per issue at no cost to you. It also provides legal assistance and financial counseling with licensed professionals at no cost to you. The ComPsych website provides information and resources on many subjects including health care, nutrition, caring for the elderly, tips for getting organized, and much more.

You can access these services by reaching out to ComPsych by phone at (833) 792-2271 (833-SWCCAP1) or online at www.guidanceresources.com using the Web ID: SWCCAP.

The CCAP is intended to help individuals manage challenges related to stress, marriage, family, work, substance abuse, financial, legal problems, and elder and child care. The CCAP services are available via in-person visits, telephonic visits, video visits and chat sessions 24/7/365. ComPsych's confidential counselors will also help coordinate care through the medical plan as appropriate. Services provided by the CCAP are available in addition to the mental/behavioral health benefits provided under the Anthem PPO and Kaiser Medical Plans.

New Enrollment Procedures Effective October 1, 2021

The Fund is implementing a change in the enrollment procedures for the Fund, which are expected to afford participants greater flexibility with making benefit changes, permitting them to occur any time of the year as long as the enrollment procedures are followed.

Effective with enrollments or enrollment changes effective on or after October 1, 2021, the Fund will no longer have an Open Enrollment period. Instead, participants will be allowed to change their elections once during any rolling 12-month period.

In order to first enroll in Fund coverage, each Eligible Participant must complete an enrollment form. You must remain in the coverage options, including enrolled dependents, you have elected for at least 12 months (unless you experience a special enrollment event). You may then change enrolled dependents by submitting a new enrollment form indicating the change to the Administrative Office. The change will go into effect the first day of the third calendar month following the date the form is received. (Example: If the Fund Office receives a dental enrollment plan change from the UHC PPO to the UHC DHMO dental plan on November 12, 2021, the plan change would be effective February 1, 2022.)

You have the option to decline Fund coverage for yourself and/or any eligible dependents. After declining coverage, if at a later date you want the Fund's coverage that you declined (opted out of) for yourself or a dependent, you may be able to take advantage of the HIPAA Special Enrollment provisions (such as if you lose eligibility for that other coverage), or you can make an election to enroll yourself or your dependent in the Fund's benefits if it has been at least 12 months since the initial decision to decline benefits.

If you established eligibility for benefits under a qualifying drywall agreement, are enrolled in the Bronze Plan, and now work (permanently) under a Collective Bargaining Agreement that does not include a Bronze Plan provision, your work hours will be treated like a reciprocal agreement; you will be credited with the actual number of work hours worked, and you will remain in the Bronze Plan until the end of the Eligibility Quarter, as long as you meet the eligibility requirements for Active Carpenters. You will have the opportunity to select the Plan Option that will be available to you beginning the first Eligibility Quarter after the permanent assignment or move. The Bronze Plan option will no longer be available after you switch out of the plan, as it is not supported by the Collective Bargaining Agreement you are (permanently) working under.

Clarification Regarding Disability Hours Credits

Effective for disabilities beginning on or after January 1, 2019, if an Active Carpenter becomes Disabled in a Work Quarter, the Active Carpenter will be credited in that Work Quarter in which disability began, and the quarter immediately following with disability hours at the rate of eight (8) hours each day the Active Carpenter is Disabled (excluding Saturdays, Sundays and holidays). If zero hours are needed to maintain eligibility in the quarter in which the disability began, disability hours will be credited in the two subsequent quarters.

Generally, in order for Disability hours to be credited, the Active Carpenter must not be receiving a Pension Benefit from the Southwest Carpenters Pension Trust. However if, after being credited with Disability Hours, the Active Carpenter receives a Social Security Disability award with a retroactive effective date that falls within the Disability Hours Credit period, this will not alone disqualify the Active Carpenter from the Disability Hours Credit.

Please refer to your Plan Document/Summary Plan Description for the full description of the Fund's Credit for Disability Hours.

New SaveOnSP Specialty Pharmacy Copay Assistance Program Effective January 1, 2021

Effective with the 2021 Plan Year, the Plan provides a Specialty Pharmacy Copay Assistance Program through SaveOnSP for certain specialty drugs. This program is intended to help both you and the Fund save money on certain specialty medications by obtaining copay assistance from drug manufacturers when it is available. If you are taking a qualifying drug, SaveOnSP will contact you to participate in the program. If enrolled in the specialty pharmacy copay assistance program, these specialty drugs will be at no cost to you after the manufacturer's coupon is applied, as the manufacturer's copay assistance is expected to completely cover the participant's cost share of the drug. If you do not enroll in the program, you must pay the full copay. The copays are set to the maximum of the current plan design or any available manufacturer-funded copay assistance. More information is available at http://www.saveonsp.com/southwestcarpenters.

You are not required to participate in the copay assistance program, however, you must participate in order to receive benefits under the plan for your qualifying specialty medications. Those who do not participate in the program will be responsible for a higher copay for certain specialty drugs, higher than the Plan's regular copayment. These copayments are subject to change, and also will not apply toward your out-of-pocket limit. **This could result in a much higher cost share for those who choose not to participate in the program.**

For questions and assistance with the Specialty Pharmacy Copay Assistance Program, contact SaveOnSP at 1-800-683-1074. For a list of specialty drugs eligible for the program, visit: www.saveonsp.com/southwestcarpenters.

Additional Bronze Medical Plan Changes Effective January 1, 2021

The Trustees are pleased to announce changes to Anthem PPO benefits under the Southwest Carpenters Bronze Medical Plan. **A summary of changes effective for services received on or after January 1, 2021 include:**

- If provided through the 911 emergency response system, services from an Emergency Medical Technician (EMT) are covered if you reasonably believe that a medical emergency existed even if you are not transported to a hospital. Municipal emergency services, such as fire rescue and paramedics, that are billed separately from emergency medical transportation are covered. These are covered at the Plan's regular benefits for ambulance services for a medical emergency.
- 90-day supplies of maintenance drugs can be obtained from any Smart90 retail pharmacy. Your physician must write a new prescription for 90-days vs. 30-days. This will reduce the number of visits to the local pharmacy.
- Physical therapy and occupational therapy are each limited to 20 sessions per calendar year, however, if additional sessions are needed beyond this limit, preauthorization must be obtained. Coverage will be provided for additional sessions if they are determined to be medically necessary.
- The Plan will pay for tests/screenings for sexually transmitted infections (STIs) when ordered by a Physician or Health Care practitioner. These will be covered at no charge, no deductible when received from an in-network provider, or at 50% coinsurance (cost share) after deductible is met when care is received from an out-of-network provider.

Attached to this Participant Notice you will find a Schedule of Medical Benefits updated to reflect these changes to your Bronze Medical Plan Anthem PPO benefits for the 2021 Plan year.

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If you have any questions about this notice, visit the Trust's website at **www.carpenterssw.org**. Or, contact the Administrative Office at (800) 293-1370 or (213) 386-8590.

Sincerely,
THE BOARD OF TRUSTEES

In accordance with ERISA reporting requirements, this document serves as your Summary of Material Modifications (SMM) to the Plan and we are advising you of these Plan changes within 60 days of the adoption of the Plan changes. Receipt of this notice does not constitute a determination of your eligibility. If you wish to verify eligibility, or if you have any questions regarding these Plan changes, contact the Administrative Office.

ATTACHMENT TO JUNE, 2021 SUMMARY OF MATERIAL MODIFICATIONS

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE BRONZE MEDICAL PLAN

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

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of-Network
Deductible • The **annual Deductible** is the amount of money you must pay each **Calendar Year** before the Plan begins to pay benefits. • Deductibles are applied to the Eligible Medical Expenses in the order in which claims are processed by the Plan. • Only Eligible Medical Expenses can be used to satisfy the Plan's Deductibles. • The Deductible applies to all covered services except where otherwise noted in this Schedule of Medical Benefits.	• There is an annual Deductible when using network providers and a separate annual Deductible when using non-network providers. Note that the Network and Out-of-Network Deductibles are not interchangeable, meaning that you may not use a portion of a network Deductible to meet an out-of-network Deductible and vice versa. • The family Deductible can be met by any combination of amounts from any family member. • See also the section on Deductibles in Chapter 4 for information on the Deductible carryover provision and common accident provision. • The Deductible does not apply to certain services noted in this Schedule, such as the Deductible does not apply to Preventive Care received from an in-network provider, ambulance services, or outpatient Prescription Drugs.	$3,000 per person $6,000 per family	$10,000 per person $20,000 per family
Out-of-Pocket Limit (Annual) The Out-of-Pocket Limit is the most you pay during a one-year period (the Calendar Year) before your medical plan starts to pay 100% for covered Essential Health Benefits received from Network providers. • Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan. • There is no Out-of-Pocket Limit on the use of Out-of-Network providers, **except that** Emergency Services performed in an Out-of-Network Emergency Room will accumulate to meet the Network Out-of-Pocket Limit. • The family Out-of-Pocket Limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than this Plan's "per person in a family" annual Out-of-Pocket Limit. • Covered outpatient Prescription Drug expenses accumulate to a separate annual outpatient Drug Out-of-Pocket limit.	• **The Bronze Plan Out-of-Pocket Limit does not include or accumulate:** a) All services and supplies provided by Non-PPO (out-of-network) providers, except in cases involving Emergency Services performed in an Out-of-Network Emergency Room which do accumulate to the In-network Out-of-Pocket Limit b) Expenses that are not considered to be Essential Health Benefits, such as Spinal Manipulation/Chiropractic treatment c) Premiums and/or self-payment contributions for coverage d) Amounts you pay for non-covered services e) Charges above what the Plan allows (above the Allowable Charge) f) Charges in excess of the Bronze Plan's maximum benefits g) Any cost-sharing under the Outpatient Prescription Drug Benefit does not apply to the Bronze Plan Out-of-Pocket Limit but does apply to meet the separate annual outpatient Prescription Drug Out-of-Pocket Limit. • The Bronze Plan Out-of-Pocket Limit does not include/accumulate outpatient Prescription Drug benefits while the Outpatient Prescription Drug Out-of-Pocket Limit does not include/accumulate other Medical plan benefits. • The Outpatient Prescription Drug Out-of-Pocket Limit does not accumulate Drug costs related to amounts you pay for Prescription Drugs obtained at walk-in retail pharmacies after the second fill of a maintenance Drug.	**Medical Plan:** $5,600 per person $11,200 per family **Outpatient Prescription Drugs**: $1,000 per person $2,000 per family	**No Out-of-Pocket Limit for use of out-of-network providers.** Exception: Emergency Services performed in an Emergency room (ER) will accumulate to the In-network Out-of-Pocket Limit.

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE BRONZE MEDICAL PLAN

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

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of-Network
Hospital Services (Inpatient) • Room & board facility fees in a semiprivate room with general nursing services. • Specialty care units within the Hospital (e.g., intensive care unit, cardiac care unit). • Lab/x-ray/diagnostic services. • Related Medically Necessary ancillary services (e.g., prescriptions, supplies). • Newborn care including newborn circumcision. See also the Maternity services row in this Schedule.	• **Preauthorization is required for elective Hospital admissions and for anesthesia services in connection with dental care,** by calling the Preauthorization Program, whose contact information is listed on the Quick Reference Chart in the front of this document. • Under certain circumstances the medical plan will pay for the facility fees and anesthesia associated with Medically Necessary dental services covered by a Dental Plan if the Bronze Plan Claims Administrator determines that hospitalization or outpatient Surgery facility care is Medically Necessary to safeguard the health of the patient during performance of dental services. The Bronze Plan does not cover the dental professional fees or dental products/supplies for the dental service that occurs at a Hospital or outpatient Surgery facility. • See the Eligibility Chapter for how to properly enroll Newborns so coverage can be considered. • Specialty care Hospitals, also called long term acute care (LTAC) Hospitals, are discussed under the Skilled Nursing Facility row in this Schedule. • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in a Hospital/health care facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters. • **Hospital Outpatient Department in an Out-of-Network Hospital:** After Deductible met, Plan pays 50% up to a Plan payment of $3,500 for outpatient department services and supplies per episode of treatment. • Benefits will not be paid for any day in which the patient is released from the Hospital on a temporary pass.	After Deductible met, Plan pays 80%	After Deductible met, Plan pays 50%.

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE BRONZE MEDICAL PLAN

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

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of-Network

Physician and Other Health Care Practitioner Services
• Benefits are payable for professional fees when provided by a Physician or other covered Health Care Practitioner in an office, Hospital, urgent care facility, Emergency room, outpatient/ambulatory Surgery center or other covered health care facility location.
• This benefit covers routine Hospital visits by Physicians for newborn care.
• Payable Physicians and Health Care Practitioner professional fees include:
  • Surgeon
  • Assistant surgeon (if Medically Necessary)
  • Anesthesia provided by a Physician or Certified Registered Nurse Anesthetist (CRNA)
  • Hospitalist, Pathologist, Radiologist, Podiatrist (DPM), Physician Assistant; Nurse Practitioner; Certified Nurse Midwife, paramedic, licensed perfusionist.
• Telemedicine services (online visit with a health care professional via video live chat) are payable. (see also the Quick Reference Chart for more information).
• See also the Family Planning, Maternity and Wellness rows where certain women's Preventive Services are payable without cost-sharing when obtained from Network providers.
• See also the Emergency Services row for payment of providers in an Emergency room.
	• **Preauthorization is required for anesthesia services in connection with dental care and other services listed in Chapter 4,** by calling the Preauthorization Program whose contact information is listed on the Quick Reference Chart in the front of this document. **Preauthorization is recommended for surgical procedures where the surgeon's fee is expected to exceed $1,500.**
	• See also the definition of Physician, Health Care Practitioner and Surgery in the Glossary Chapter.
	• The Plan Administrator or its Delegate will determine if multiple surgical or other medical procedures will be covered as separate procedures or as a single procedure based on the factors in the definition of "Surgery" in the Glossary Chapter.
	• **Assistant Surgeon fees** will be reimbursed only for Medically Necessary services to a maximum of 20% of the eligible expenses allowed for the primary surgeon; however, the maximum is 10% of the Allowable Charge for the primary surgeon for the services of a state licensed Registered Nurse first assistant or state licensed Physician assistant.
	• Under this Plan, there is no requirement to select a primary care Physician (PCP) or to obtain a referral or prior authorization before visiting an OB/GYN provider.
	• **Provider Hospital Visits**: Not more than one visit to or by the same Physician is covered per day unless the patient is confined as a registered bed patient in a Hospital or Extended Care Facility. For purposes of this limitation, multiple office visits are considered to have occurred in a single day if the Physician bills more than one office visit charge for the same date of service and regardless of whether or not the patient had a return trip to the Physician's office.
	• **Newborn circumcision** is payable. An office visit for a **second or third opinion** is payable.
	• Generally there is no coverage for eye refraction, eyeglasses, contact lenses, or the fitting of eyeglasses or contact lenses; however see the Corrective Appliance row in this Schedule for more details. Surgical correction of refractive errors in vision is not covered, including but not limited to LASIK or similar procedures, except surgical correction is payable when the patient's vision cannot be corrected to 20/40 or better by eyeglasses or contact lenses (coverage is payable for one Surgery for each eye during a person's lifetime, up to a maximum Plan payment of $1,000 for each Surgery).
	• No coverage for acupuncture.
	• Routine Foot Care is not covered; however, foot care is payable when Medically Necessary for individuals with diabetes or a neurological or vascular insufficiency affecting the feet.
		Online visit with a health care professional via video live chat: You pay $5.00/visit, Deductible does not apply.
		
		All other services: After Deductible met, Plan pays 80%
		
		For second surgical opinion: deductible waived and Plan pays 100% of Allowable charge, up to $150. Allowable charges in excess of $150 are paid at 80%.
			After Deductible met, Plan pays 50%.
			
			For second surgical: opinion deductible waived and Plan pays 100% of Allowable charge, no deductible, up to $150. Allowable chares in excess of $150 are paid at 70% after deductible met

Allergy Services • Allergy sensitivity testing, including skin patch or blood tests such as Rast or Mast. • Desensitization and hyposensitization (allergy shots given at periodic intervals). • Allergy antigen solution.	• Allergy services are covered only when ordered by a Physician.	Testing, Allergy Shots, Allergy Antigen: After Deductible met, Plan pays 80%.	Testing, Allergy Shots, Allergy Antigen: After Deductible met, Plan pays 50%.

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE BRONZE MEDICAL PLAN This chart explains the benefits payable by the Plan. See also the Exclusions and Glossary Chapters of this document for important information. All benefits are subject to the Deductible except where noted. *IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Glossary Chapter, and could result in Balance Billing to you.			
BENEFIT DESCRIPTION	**EXPLANATIONS AND LIMITATIONS OF BENEFITS**	**PPO In-Network**	**Out-of-Network**

Ambulance Services for Medical Emergency
• **Ground vehicle Emergency transportation:**
  • to the nearest appropriate facility as Medically Necessary for treatment of a medical Emergency or acute illness/injury;
  • for Medically Necessary inter-health care facility transfer (e.g. transfer from one Hospital to another Hospital or trip to and from one Hospital to another in order to obtain a special test/procedure).
  • If provided through the 911 emergency response system, ambulance services are covered if you reasonably believe that a medical emergency existed even if you are not transported to a hospital.
• **Air/sea Emergency transportation** is payable: (1) only when Medically Necessary for treatment of a life-threatening Emergency, and (2) the air/sea transport is required because of inaccessibility by ground transport and/or the use of ground transport would endanger the patient's health status. When air/sea ambulance transportation is required, it is **payable to the nearest acute health care facility qualified to treat the patient's Emergency condition**.
• Medically necessary Non-Emergency medical transportation.
	• Expenses for ambulance services are covered only when those services are for an **Emergency,** as that term is defined in the Glossary Chapter of this document under the heading of "Emergency Care," or for Medically Necessary inter-health care facility transport.
	• Municipal emergency services such as fire rescue and paramedics that are billed separately from emergency medical transportation are covered.
	• **Non-Emergency medical transportation** refers to transport of an individual in a vehicle because the individual cannot safely use public or private transportation due to their Medically Necessary requirement to be positioned in a wheelchair or stretcher, or because they require the use of medical equipment or non-Emergency medical monitoring during transport. Non-Emergency medical transportation is not covered if used for convenience of the patient or their family. **Preauthorization is required for Non-Emergency medical transportation services,** by calling the Preauthorization Program, whose contact information is listed on the Quick Reference Chart in the front of this document. See Chapter 4 for details. When preapproved, the Plan may pay toward the least expensive and appropriate method of transportation that meets the physical and medical circumstances of the individual and the Plan reserves the right to limit its payment of transportation to the nearest appropriate location (such as the nearest provider of medical services when it has made a determination that traveling further distances provides no medical benefit to the individual).
		Emergency Transport: You pay a $50 Copay per trip, Deductible does not apply.	**Emergency Transport:** You pay a $50 Copay per trip, Deductible does not apply.
			(Maximum Allowable Charge is up to $50,000 per trip for an air ambulance and up to $1,075 per trip for a ground ambulance.)

Ambulatory Surgical Center	• See the Outpatient (Ambulatory) Surgery Facility row in this Schedule.		

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE BRONZE MEDICAL PLAN

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

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of-Network
Behavioral Health Services **(Mental Health and Substance Abuse Treatment)** • **ComPsych Carpenters Assistance Program (CCAP) Services:** This plan offers up to 5 free CCAP visits per problem per year for professional confidential counseling at no cost to you. The phone number for the CCAP program is 1-833-SWCCAP1. • **Outpatient visits:** including necessary Psychological (Psychiatric) Testing. • **Other Outpatient Services**: partial day care/partial hospitalization or intensive outpatient program (IOP) care. See the Glossary Chapter for the meaning of the term partial day care. • **Inpatient acute Hospital admission**, or Residential Treatment Program. See the Glossary Chapter for the meaning of the term residential treatment. • Screening for tobacco use; and, for those who use tobacco products, the Plan covers at least two tobacco cessation attempts per year. Cessation support described to the right. • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in a Hospital/health care facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters.	• **Preauthorization is required for elective inpatient hospital admissions, inpatient residential treatment program admissions, and partial hospitalization/partial day care in connection with Mental Health and/or Substance Abuse treatment** by calling the Preauthorization Program, whose contact information is listed on the Quick Reference Chart in the front of this document. See Chapter 4 for details. • CCAP counselors are available to help you 24/7/365 with challenges related to stress, marriage, family, work, substance abuse, financial, legal problems, and elder and child care referral. • Benefits will not be paid for any day in which the patient is released from the Hospital on a temporary pass. • For assistance locating Behavioral Health providers best qualified to treat your needs please contact the telephone number on your ID card. • Behavioral Health **Residential Treatment Program** is covered for individuals needing treatment in a highly structured 24-hour therapeutic environment when care cannot be safely or effectively treated in a less intensive setting. A Residential Treatment Facility must be properly licensed in the state in which the facility operates. • Outpatient Prescription Drugs for Behavioral Health payable under Drugs in this Schedule of Medical Benefits. • Programs based on learning theories and motivation, such as Applied Behavior Analysis (ABA) Therapy, are a covered benefit. • **Tobacco Cessation support**: The Plan covers, at no cost for Network providers, at least two tobacco cessation attempts per person per year. ○ A cessation attempt includes coverage for four (4) tobacco cessation **counseling sessions** of at least 10 minutes each (including telephone counseling, group counseling and/or individual counseling with a licensed counselor, without preauthorization requirements). ○ All **FDA-approved tobacco cessation medications** (including both prescription and over-the-counter medications) are covered at no cost from Network retail pharmacy locations for a 90-day treatment regimen when prescribed by Physician or Health Care Practitioner (without preauthorization). See also the Drug chart on page 62 and the Drug row in this Schedule. • Coverage for marriage or family counseling is limited to a maximum benefit of 12 visits per person per Calendar Year. Not more than one visit is covered per day • Benefits are payable for a maximum 8 hours per disability for **psychometric testing** and 4 visits per disability for **biofeedback** services.	**CCAP Visits:** No charge **Outpatient visits, Other Outpatient Services, Inpatient Hospital and Residential Treatment Program:** After Deductible met Plan pays 80%. Tobacco Cessation Counseling: No charge. Deductible does not apply.	**Outpatient visits, Other Outpatient Services, Inpatient Hospital and Residential Treatment Program:** After Deductible met Plan pays 50%. Tobacco Cessation Counseling: Not covered.
Birthing Center/Facility	• See the Maternity Services row of this Schedule.		
Blood Transfusions • Blood transfusions and blood products and equipment for its administration.	• Covered only when ordered by a Physician.	After Deductible met, Plan pays 80%.	After Deductible met, Plan pays 50%.

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE BRONZE MEDICAL PLAN

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

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of-Network
Chemotherapy • Chemotherapy Drugs and supplies administered under the direction of a Physician in a Hospital, Health Care Facility, Physician's office or at home.	• Benefit payments may vary depending on the location in which the chemotherapy is delivered or received by the patient. For example, if chemotherapy is delivered in a Hospital, the Hospital Services coverage applies; if it is delivered at home or in a Physician's office, see Physician's and Other Health Care Practitioners row (above) in this Schedule of Medical Benefits.	Payment may vary according to the location in which the service is provided.	Payment may vary according to the location in which the service is provided.
Chiropractic Services	• See the Spinal Manipulation section of this Schedule of Medical Benefits.		
Circumcision • Circumcision for newborn males, birth through 2 years of age.		After Deductible met, Plan pays 80%.	After Deductible met, Plan pays 50%.

Corrective Appliances (Prosthetic & Orthotic Devices, other than Dental)
• Coverage is provided for Medically Necessary Prosthetic and Orthotic devices as follows:
  • rental (but only up to the allowed purchase price of the device).
  • purchase of standard model. Rental or purchase determined by the Plan Administrator or its Delegate.
  • repair, adjustment or servicing of the device when Medically Necessary.
  • replacement of the device is payable if there is a change in the covered person's physical condition making the current device inoperable or unsatisfactory in order to perform normal daily activities (as certified by the patient's Physician), or if the device cannot be satisfactorily repaired.
• Corrective Appliances are covered only when ordered by a Physician or Health Care Practitioner.
• For hearing services see the Hearing Services row in this Schedule.
	• See the exclusions related to Corrective Appliances in the Exclusions Chapter 6. To help determine what Prosthetic or Orthotic Appliances are covered, see the definitions of "Prosthetics" and "Orthotics" in the Glossary Chapter.
	• Plan covers Prosthetic devices like artificial limbs or eyes. Replacement of a Prosthetic device is covered for a Dependent child when Medically Necessary as a result of the child's growth.
	• **Orthotics (non-foot):** such as a cast, splint, brace such as a back brace or knee brace, are payable when Medically Necessary. A custom-made Orthotic device is payable where there is a failure, contraindication, or intolerance to an unmodified, prefabricated (off-the-shelf) Orthotic device.
	• **Foot Orthotics** (orthopedic or corrective shoes and other supportive appliances for the feet) are payable (one pair every 12 months for adults). One pair of foot Orthotics payable once in a period of 6 months for children under age 19 when replacement is required due to growth.
	• The Plan covers a single wig, toupee or hairpiece per person per lifetime.
	• One eye examination and one pair of Medically Necessary eyeglasses or contact lenses are payable after the surgical removal of the lens of the eye, such as with a cataract extraction.
		After Deductible met, Plan pays 80%.	After Deductible met, Plan pays 50%.

Diabetes Education	• Coverage is payable for diabetes education.	After Deductible met, Plan pays 80%.	After Deductible met, Plan pays 50%.

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE BRONZE MEDICAL PLAN

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of-Network
Dialysis • Dialysis for the treatment of acute kidney failure, end-stage kidney disease and chronic kidney disease. • Hemodialysis or peritoneal dialysis and supplies administered under the direction of a Physician in a Hospital, Health Care Facility, Physician's office or at home. • If you are eligible for Medicare but do not reenroll in both Medicare Part A and Part B after the 30-month coordination period is completed, this Plan will pay benefits as if you have enrolled. After the 30-month coordination period is completed, your claims will be reduced as secondary under this Plan regardless of your enrollment status under Medicare. As a result, in order to receive the maximum amount of coverage to which you may be entitled under Medicare, you should consider enrolling in and paying any premiums required for Medicare coverage, including Part B, no later than the end of the 30-month coordination period.	• Benefit payments may vary depending on the location in which the hemodialysis or peritoneal dialysis is performed or received by the patient. • When you have reached the end stage of kidney failure (renal impairment) that causes your Physician to recommend a kidney transplant or regular course of dialysis, you may be eligible for Medicare. **It is important that individuals with end stage renal disease (ESRD) promptly apply for Medicare coverage, regardless of age**. If you qualify for Medicare Part A (coverage for Hospitals), you can also get Medicare Part B (coverage for outpatient services, ambulance, DME). Enrolling in Part B is your choice, but you'll need both Medicare Part A and Part B to get the full benefits available under Medicare to cover certain dialysis and kidney transplant services. • See also the Coordination of Benefits Chapter 9 that discusses what this Plan pays when you are also Medicare eligible. • **Medicare and ESRD:** Once you are eligible for Medicare, you should apply for enrollment in Medicare. If the application for enrollment is accepted, Medicare coverage may begin. Medicare coverage begins at different times for different people depending on the circumstances. Medicare coverage usually starts the first day of the 3rd month after the month in which a course of regular dialysis begins. All, or a portion of, the 3-month waiting period may be waived if you participate in a self-dialysis training program, or if you have a kidney transplant within the 3-month waiting period. **When you are on dialysis and covered by both Medicare and this group health plan, for the first 30 months (referred to a 30-month coordination period), your group health plan is the primary payer of your dialysis and other covered medical services.** It is important to note that the 30-month coordination period always begins on the date you are first eligible to enroll in Medicare due to ESRD. If for example, you fail to submit a timely application for Medicare or choose not to apply for Medicare, the 30-month coordination period will be calculated with a start date based on the month in which you could have been enrolled, had you made an application for Medicare. Medicare becomes the primary payer of benefits after the 30-month coordination period ends, as long as you retain Medicare eligibility based on ESRD. A Medicare beneficiary may have more than one 30-month coordination period. Medicare entitlement (meaning eligibility and coverage under Medicare) because of ESRD, will end if you have not received dialysis for 12 months, or if 36 months have passed since you had a successful kidney transplant.	Payment may vary according to the location in which the service is provided.	Payment may vary according to the location in which the service is provided.
Dietitian Services • See also the Diabetes Education row in this Schedule.	• Certain dietary counseling may be payable as a Wellness service in accordance with requirements of the Affordable Care Act (ACA). • As a preventive counseling benefit in compliance with the Affordable Care Act (ACA), the Plan covers the following services: For adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.	Preventive Counseling Benefit: 100% no Deductible	Preventive Counseling Benefit: 100% no Deductible

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE BRONZE MEDICAL PLAN

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

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of-Network

Drugs (Outpatient Medicines)
• Coverage is provided for those pharmaceuticals (drugs and medicines) approved by the US Food and Drug Administration (FDA) as requiring a prescription and are FDA approved for the condition, dose, route, duration and frequency, if prescribed by a Physician or other Health Care Practitioner authorized by law to prescribe them.
• Contact the Prescription Benefit Manager (PBM) (whose phone number is listed on the Quick Reference Chart in the front of this document) for the following:
  ◦ The Drugs on the **National Preferred Formulary**.
  ◦ Information on Drug**s requiring preauthorization** (pre-approval) by the clinical staff of the Prescription Benefit Manager (PBM), such as growth hormones, interferon, controlled substance for pain treatment, Retin-A over age 25, hepatitis C Drugs, Botox, certain brand name Drugs and testosterone replacement.
  ◦ Information on which Drug**s have a limit to the quantity** payable by this Plan, such as sleeping pills.
  ◦ Information on which Drugs are part of the **step therapy program** where you first try a proven, cost-effective medication before moving to a more costly Drug option.
  ◦ **Specialty Drugs** are available on an outpatient basis when ordered through and managed by the Prescription Benefit Manager (PBM). Specialty Drugs are generally considered high-cost injectable, infused, oral or inhaled products that require close supervision and monitoring and are used by individuals with unique or chronic conditions such as multiple sclerosis, rheumatoid arthritis, Crohn's disease, psoriasis, cancer or hepatitis. These Drugs **need prior authorization**, often require special handling, are date sensitive and are generally available only in a 30-day quantity.
	The Prescription Drug Program: Benefits for Prescription Drugs are provided through the Plan's Prescription Benefit Manager (PBM) whose name is listed on the Quick Reference Chart in the front of this document.
	• **If the cost of the Drug is less than the Copay, you pay just the Drug cost.**
	• **Retail Drugs**: To obtain up to a 30-day supply of medicine for the Copay noted to the right (or 90-day supply if a Smart90 retail pharmacy is used), present your ID card to any Network retail pharmacy. Contact the Prescription Benefit Manager (PBM) (whose name is listed on the Quick Reference Chart) for the location of Network and Smart90 retail pharmacies.
	• **Note that after a maintenance Drug has been filled two times at a retail pharmacy, you are REQUIRED TO OBTAIN any future refill of that maintenance Drug through the Mail Order Pharmacy or a Smart90 Retail Pharmacy or else pay the full cost of the Drug**.
	• **Mail Order (Home Delivery) Drug Service:** The mail order service is the easiest and least expensive way to obtain many maintenance use Drugs, plus the medications are mailed directly to your home. You may use the mail order service (see the Quick Reference Chart) to receive up to a 90-day supply of non-Emergency, extended-use "maintenance" Prescription Drugs, such as for high blood pressure, high cholesterol, or diabetes. Note that not all medicines are available via mail order. Check with the Prescription Benefit Manager (PBM) for further information. To use the mail order service, have your doctor write the prescription for a 90-day supply, with the appropriate refills. Then, mail your prescription, Copay and the mail order form to the Mail Order Services of the Prescription Benefit Manager (PBM) whose address is listed on the Quick Reference Chart. Mail order forms may be obtained from the Prescription Benefit Manager (PBM). Allow up to 14 days to receive your order.
	• **Direct Member Reimbursement for use of an Out-of-Network Retail Pharmacy**: If you fill a prescription at an Out-of-Network pharmacy location, you will need to pay for the Drug at the time of purchase and later (within 1 year), send your Drug receipt to the Prescription Benefit Manager (PBM) using the Direct Member Reimbursement (DMR) process. DMR forms may be obtained from the Prescription Benefit Manager (PBM). Be sure to send a copy of the pharmacy Drug receipt and sign the DMR claim form. For eligible prescriptions, the Plan reimburses 80% of what it would have paid had you used a network pharmacy and you pay a $60 Copay plus 20% Coinsurance. Note: Specialty Drugs are not payable out-of-network, plus, foreign Drug claims and allergy Drug claims are not covered through direct member reimbursement.
	• The Plan provides a **mandatory generic program** meaning that if a brand name Drug is dispensed in place of a generic Drug, regardless if you or your doctor request it, **you will pay the brand Copay plus the difference in cost** between the generic and brand name Drug.
	• Certain specialty pharmacy drugs are considered non-essential health benefits, as defined by the ACA, under the Plan and the cost of such drugs, or a manufacturer coupon used to pay for these drugs, will **not** be applied toward satisfying your out-of-pocket maximum. The Plan provides a **Specialty Pharmacy Copay Assistance Program** for these specialty drugs. If enrolled in the specialty pharmacy copay assistance program, these specialty drugs will be at no cost you after the manufacturer's coupon is applied. If you do not enroll in the program, you pay the full copay, and the copays are be set to the maximum of the current plan design or any available manufacturer-funded copay assistance. More information is available at http://www.saveonsp.com/southwestcarpenters.
		No Deductible applies to outpatient Drugs.
		
		Annual Calendar Year Out-of-Pocket Limit for outpatient Drugs is $1,000/person; $2,000/family.
		
		Network Retail Pharmacy (up to a 30-day supply):
		Generic: $10 Copay.
		Preferred (Formulary) Brand: $40 Copay
		Non-Preferred Brand: $60 Copay
		Specialty Pharmacy Copay Assistance Program Drugs: copays are subject to change. See http://www.saveonsp.com/southwestcarpenters for more information
		All Other Specialty Drugs: $50 Copay
		ACA-mandated No Cost Drugs: FDA-approved female contraceptives, certain Drugs to reduce the risk of breast cancer, low dose statins, aspirin, tobacco cessation Drugs and certain over-the-counter Drugs.
		
		Mail Order Service or Smart90 Retail Pharmacy (up to a 90-day supply):
		Generic: $25 Copay
		Preferred (Formulary) Brand: $100 Copay
		Non-Preferred Brand: $150 Copay
		Specialty Pharmacy Copay Assistance Program Drugs: copays are subject to change. See http://www.saveonsp.com/southwestcarpenters for more information
		All Other Specialty Drugs: $100 Copay	

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE BRONZE MEDICAL PLAN

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of-Network
Drugs (Outpatient Medicines) (continued from previous row) • The Plan provides a **Specialty Pharmacy Copay Assistance Program** for certain specialty drugs. • Covered outpatient Prescription Drugs do accumulate to meet an **annual Drug Out-of-Pocket Limit** but does not include amounts you pay for Prescription Drugs obtained at walk-in retail pharmacies after the second fill of a maintenance Drug. • Drugs not yet FDA-approved are not covered. New FDA-approved Drugs will be covered unless an amendment states otherwise, or the class of Drug is excluded.	• Prescription Drug coverage under this Plan is considered to be creditable (as valuable as) Medicare Drug coverage. • Non-sedating antihistamine medication (e.g. Claritin, Zyrtec) are excluded; however, if the prescription is filled at a Participating Pharmacy, the Eligible Individual is only responsible for 100% of the contracted price for such medication. • No coverage for male contraceptives, injectable forms of erectile dysfunction treatment, Cosmetic Drugs, anti-obesity Drugs, and fertility treatment Drugs. See also the exclusions related to Drugs (Medicines) in the Exclusions Chapter 6. • In accordance with the Affordable Care Act (ACA, certain **over-the-counter (OTC) and Prescription Drugs** are payable at no charge when prescribed and filled at a network pharmacy. For details, see the Drug chart on page 62. For **FDA-approved contraceptives for females:** 100%, no cost-sharing for generic contraceptives. No charge for brand prescription contraceptives only if a generic contraceptive is unavailable or medically inappropriate as determined by the attending provider. • Certain **CDC recommended vaccinations** are payable at 100%, no cost sharing when obtained at a network retail pharmacy. Contact the Prescription Drug Program for more information.	**Use of an Out-of-Network Retail Pharmacy**: If you fill a prescription at an Out-of-Network retail pharmacy location, you will need to pay for the Drug at the time of purchase and later, send your Drug receipt to the Prescription Benefit Manager (PBM) using the Direct Member Reimbursement (DMR) process as described to the left.	
Durable Medical Equipment (DME) • Coverage is provided for: • purchase of standard model equipment. • rental or purchase determined by the Plan Administrator or its Delegate; • repair, adjustment or servicing of Medically Necessary DME; • replacement of Medically Necessary Durable Medical Equipment is covered if there is a change in the covered person's physical condition making the equipment not functional/unsafe, or if the equipment cannot be satisfactorily repaired at a lesser expense; • supplies that are necessary for the function of the Durable Medical Equipment are also covered so long as the equipment is Medically Necessary for the individual who is covered under this Plan. • Coverage is provided for Medically Necessary oxygen, along with the Medically Necessary equipment and supplies required for oxygen administration. • Coverage is provided for diabetic blood glucose meter and other Medically Necessary diabetes Durable Medical Equipment.	• **Preauthorization of certain Durable Medical Equipment is required** by calling the Preauthorization Program whose contact information is listed on the Quick Reference Chart in the front of this document. See also Chapter 4 for details. • If more than one piece of DME can meet the functional needs, benefits are available only for the most cost-effective piece of Durable Medical Equipment. • To help determine what Durable Medical Equipment is covered, see the definition of "Durable Medical Equipment" in the Glossary Chapter. • Durable Medical Equipment (and supplies necessary for the function of the Durable Medical Equipment) is covered only when its use is Medically Necessary and it is ordered by a Physician or Health Care Practitioner. • For females who are breastfeeding, coverage is provided for a standard manual or standard electric breast pump, plus the breast pump supplies necessary to operate the breast pump. A Hospital grade breast pump is payable if the Plan determines it to be Medically Necessary. The cost of renting or purchasing breastfeeding equipment extends for the duration of breastfeeding for the child. Rental, purchase and repair is payable as outlined to the left. • Benefits may be payable for the purchase of Durable Medical Equipment including a maintenance agreement if the Claims Administrator determines that it is cost effective. The amount of benefits payable for the purchase of Durable Medical Equipment will be reduced by any benefits paid for the rental of such equipment. • Costs associated with the customization or personalization of Durable Medical Equipment and comfort, convenience or luxury equipment, are not covered. See the exclusions related to Corrective Appliances and Durable Medical Equipment in the Exclusions Chapter 6.	Breast pump and supplies necessary to operate pump: No charge. Deductible does not apply. All other DME: After Deductible met Plan pays 80%.	Breast pump and supplies necessary to operate pump: No charge. Deductible does not apply. All other DME: After Deductible met Plan pays 50%.

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of-Network
Emergency Room Facility, Urgent Care Facility • Hospital Emergency room (ER) for "Emergency Services" (as that term is defined in this Plan). • Urgent Care facility. Common medical conditions that may be appropriate for a Physician office or Urgent Care facility (instead of an Emergency Room) include, but are not limited to, fever, sore throat, earache, cough, flu symptoms, sprains, bone or joint injuries, diarrhea or vomiting, or bladder infections. • Ancillary charges (such as lab or x-ray) performed **during** the ER or Urgent care visit. • (See also the Ambulance section of this schedule.) • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in an Emergency room or urgent care facility are usually billed separately from the facility fee. Both the Emergency room visit facility and professional fees are payable as part of the Emergency room visit in this row.	• Expenses for Emergency Room services are covered only when those services are for an **Emergency** as that term is defined in the Glossary Chapter of this document under the heading of "Emergency Services." • **Emergency room facility services** are subject to a Copayment per visit. The Copayment will be waived if a subsequent immediate Hospitalization is required. • There is no requirement to preauthorize the use of a Hospital-based Emergency room visit. • The Plan will pay a reasonable amount for Hospital-based Emergency Services performed Out-of-Network, in compliance with Affordable Care Act (ACA) regulations. See the definition of Allowed Charge and Emergency Services. Contact the Bronze Plan Claims Administrator for details on what the Plan allows as payment to Out-of-Network Emergency Service providers.	**Emergency Services in an Emergency Room**: You pay a $250 Copay per visit then Plan pays balance at 80% of the Allowed Charge after the Deductible is met. **Urgent Care Facility**: After Deductible met, Plan pays 80%.	**Emergency Services in an Emergency Room**: You pay a $250 Copay per visit then Plan pays balance at 80% of the Allowed Charge after the Deductible is met. **Non-Emergency Services in an Emergency Room:** You pay a $250 Copay per visit then Plan pays balance at 50% of the Allowed Charge after the Deductible is met. **Urgent Care Facility**: After Deductible met, Plan pays 80%.
Extended Care Facility	• See the Skilled Nursing Facility row in this Schedule.		

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of-Network
Family Planning, Reproductive, Contraceptive Fertility Services • Sterilization services (e.g., vasectomy, tubal ligation, implants). • Coverage is provided for ACA mandated (Preventive Service) FDA-approved **female contraceptives** such as oral birth control pills/patch, Emergency contraception, injectables (e.g., Depo-Provera, Lunelle), intrauterine device (IUD) and removal of IUD, cervical cap, contraceptive ring (e.g. NuvaRing), diaphragm, implantable birth control device/service (e.g. Implanon, Nexplanon). See also the Drug row in this Schedule for information on FDA-approved contraceptive coverage where there is no charge for generic FDA-approved contraceptives submitted with a prescription and obtained from a network pharmacy location or from mail order. No charge for a brand prescription contraceptive only if a generic contraceptive is unavailable or medically inappropriate as determined by the Physician. No coverage for FDA approved contraceptives obtained from a Non-Network retail pharmacy. • Fertility and infertility services include evaluation (diagnosis), only. • Non-injectable treatment for male erectile dysfunction is covered. See the Drug row of this Schedule.	• For maternity coverage see the Maternity row in this schedule. • No coverage for reversal of sterilization procedures. No coverage for the treatment of infertility. • **Certain contraceptives are payable under the row on Drugs (Medicines)** coverage. In accordance with ACA, there is no cost-sharing for FDA-approved female contraceptives and female sterilization services and benefits will be paid at 100% no Deductible, in-network only. Certain contraceptives are available through the Prescription Drug Program (see the Drug row of this Schedule). • No coverage for injectable forms of treatment for male erectile dysfunction (e.g., Caverject). See the specific exclusions related to Drugs, Medicines and Nutrition; Fertility and Infertility; Maternity Services; and Erectile Dysfunction Services in the Exclusions Chapter 6.	Female Contra-ceptives and Female sterilization procedures: 100%, no Deductible. For other services: After Deductible met, Plan pays 80%.	After Deductible met, Plan pays 50%.

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE BRONZE MEDICAL PLAN

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of-Network
Genetic Testing and Counseling • Medically necessary Genetic Testing payable under this Plan is for: a) state-mandated newborn screening tests for genetic disorders; b) Genetic Testing (e.g. BRCA, stool DNA testing like Cologuard) and Genetic Counseling required as a Preventive service in accordance with the Affordable Care Act (ACA) regulations (see the Wellness row in this Schedule). c) fluid/tissue obtained as a result of amniocentesis, chorionic villus sampling (CVS), and alpha-fetoprotein (AFP) analysis in covered pregnant women and only if the procedure is Medically Necessary as determined by the Plan Administrator or its Delegate; d) tests to determine sensitivity to FDA approved Drugs, such as the Genetic Test for warfarin (blood thinning medication) sensitivity; e) Genetic Testing recommended by the American College of Obstetrics and Gynecology for pregnant women such as prenatal genetic screening for cystic fibrosis; f) the detection and evaluation of chromosomal abnormalities or genetically transmitted characteristics in covered participants if all the following conditions are met: • the testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and • the covered individual displays clinical features/symptoms, or is at direct risk (family history or 1st or 2nd degree relative) of developing the genetically linked heritable disease/condition in question (pre-symptomatic); and • the results of the test will directly impact clinical decision-making; outcome or treatment being delivered to the covered individual.	• Participants can contact the Medical Plan Claims Administrator for guidance on whether a proposed Genetic Test is a covered benefit. • Genetic Counseling is payable when ordered by a Physician, performed by a qualified Genetic Counselor (or other qualified health care provider) and provided with regard to a Genetic Test that is payable by this Plan. Certain Genetic Counseling is payable as a Preventive service in accordance with the Affordable Care Act (ACA) regulations. • See the definitions of Genetic Counseling, Genetic Testing in the Glossary Chapter. • See the Exclusions Chapter 6 for exclusions relating to Genetic Testing and Counseling, in addition to those indicated here.	Affordable Care Act (ACA) required Genetic Tests & counseling: 100% no Deductible. All other services: After Deductible met, Plan pays 80%.	After Deductible met, Plan pays 50%.

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of-Network
Hearing Services • An audiological evaluation to measure the extent of hearing loss and to determine the most appropriate make and model of hearing aid. • An external hearing aid (monaural or binaural) is covered including the ear mold(s), the external hearing aid, batteries, cords and other ancillary equipment. • The Plan covers visits for hearing aid fitting, counseling, adjustments, and repairs for the covered hearing aid. • Implantable hearing device, such as a cochlear implant, is covered when Medically Necessary.	• Hearing (audiology) exam is payable like a Physician office visit. • Coverage for a Medically Necessary **external hearing aid** is payable up to **$1,000 per hearing device, payable once each 24 months,** when accompanied by a written recommendation from an otolaryngologist (Physician specializing in ear and throat disorders) or state-certified audiologist (provider trained to evaluate hearing loss and related disorders). • No coverage for charges for an implantable hearing aid which exceeds the device prescribed for the correction of hearing loss, or a hearing aid that is not Medically Necessary. • No coverage for external hearing aids or the fitting of hearing aids	Audiology Exam: After Deductible met, Plan pays 80%. External Hearing Aid: After Deductible met, Plan pays 80%. Implantable hearing device: After Deductible met, Plan pays 80%.	Audiology Exam: After Deductible met, Plan pays 50%. External Hearing Aid: After Deductible met, Plan pays 80%. Implantable hearing device: After Deductible met, Plan pays 50%.
Home Health Care and Home Infusion Therapy Services • Part-time, intermittent **Skilled Nursing Care** services and Medically Necessary supplies to provide in-home Home Health Care or home infusion services. • When a Registered Nurse or licensed vocational nurse provides services, benefits will be paid only for those services rendered by the nurse that require the skill and training of the nurse. • These benefits do not cover services of a nurse's aide, Custodial Care or housekeeping services.	• **Preauthorization of Home health care and Home Infusion therapy is required** by calling the Preauthorization Program whose contact information is listed on the Quick Reference Chart in the front of this document. See also Chapter 4 for details. • See the exclusions related to Home Health Care and Custodial Care (including personal care and childcare) in the Exclusions Chapter 6 of this document. • Home Hospice coverage is payable under Hospice benefits. • Home Physical Therapy services coverage is payable under the Rehabilitation Services benefits.	After Deductible met, Plan pays 80%.	After Deductible met, Plan pays 50%.
Hospice • Hospice services (palliative care for terminally ill persons and likely to result in death within a 180-day/6-month period) include inpatient hospice care and outpatient home hospice care. • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in a hospice inpatient facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters.	• **Preauthorization of hospice services is required** by calling the Preauthorization Program whose contact information is listed on the Quick Reference Chart in the front of this document. See also Chapter 4 for details. • Covered only when ordered by a Physician. • Hospice benefits are payable for a period of up to 180 days per lifetime (whether or not there has been a disruption in coverage). • Hospice care will not be paid if the hospice program is not certified by Medicare.	Home hospice or Inpatient hospice: After Deductible met, Plan pays 80%.	Home hospice or Inpatient hospice: After Deductible met, Plan pays 80%.

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE BRONZE MEDICAL PLAN

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

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of-Network
Laboratory Services (Outpatient) • Technical and professional fees.	• Covered only when ordered by a Physician or Health Care Practitioner. • Inpatient Laboratory Services are covered under the Hospital Services section of this Schedule of Medical Benefits. • Some laboratory services are payable under the Preventive (Wellness) benefits in this Schedule.	After Deductible met, Plan pays 80%.	After Deductible met, Plan pays 50%.
Maternity Services • Hospital and medical services and supplies in connection with the pregnancy of an Eligible Individual who is a female employee or Dependent Spouse are covered on the same basis as an illness. • Plan covers Hospital and Birth (Birthing) Center charges and Physician and Certified Nurse Midwife fees for Medically Necessary maternity services. • Coverage for the baby is only payable if the child is a Dependent Child as defined in this Plan, and properly enrolled in a timely manner. See the Eligibility Chapter on how to enroll a Newborn Dependent Child(ren). • Breastfeeding equipment (breast pump) and supplies needed to operate the pump are payable as noted on the Durable Medical Equipment row of this Schedule. • For females who are breastfeeding, the Plan pays for comprehensive lactation support and counseling (including breastfeeding classes) at 100%, no Deductible, when provided by a network provider acting within the scope of the provider's license. Network providers are listed on the network directory described on the Quick Reference Chart. • Elective induced (voluntary) abortion. • See Genetic Testing row for additional information. See the Family Planning row and Drug row for information on contraceptive coverage.	• **The Plan does pay for Affordable Care Act (ACA) mandated expenses related to the maternity care associated with all females including a pregnant Dependent child, but the Plan DOES NOT pay for ultrasounds and delivery expenses for pregnant Dependent children or for a pregnant Dependent child who has elected COBRA.** • Certain prenatal care/maternity related Preventive Care expenses are payable for all females (as listed on the government websites at http://www.hrsa.gov/womensguidelines/ or https://www.healthcare.gov/what-are-my-preventive-care-benefits/ including but not limited to routine prenatal obstetrical office visits, screening for gestational diabetes, HPV testing starting at age 30, blood pressure screening throughout a pregnancy to check for preeclampsia, and when breastfeeding there is coverage for breastfeeding equipment and supplies need to operate the equipment and comprehensive lactation support and counseling). These services are covered without cost sharing for a female when obtained from Network providers. • **Hospital Length of Stay for Childbirth:** Under federal law, group health plans, like this Plan, generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., Physician, or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans may not set the level of benefits or Out-of-Pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. If you deliver in the Hospital, the 48-hour period (or 96-hour period) starts at the time of delivery. In addition, the Plan may not, under federal law, require that a Physician or other Health Care Practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your Out-of-Pocket costs, you may be required to obtain preauthorization. **For information on preauthorization for a length of stay longer than 48 hours for vaginal delivery or 96 hours for C-section delivery, contact the Preauthorization Program to preauthorize the extended Hospital stay.** Refer to Chapter 4 for information on preauthorization. • You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. • Elective induced (voluntary) abortion is covered only for the covered employee or covered Spouse.	Prenatal and postnatal office visits and ACA-mandated Preventive Services: No charge, Deductible does not apply. Lactation counseling and breast-feeding equipment and supplies: No charge, Deductible does not apply. For Delivery fees: refer to Physician and Hospital rows of this schedule.	After Deductible met, Plan pays 50%.
Mental Health and Substance Abuse/Substance Use Disorder Treatment	• See the Behavioral Health row of this Schedule.		

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE BRONZE MEDICAL PLAN

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of-Network

Nondurable Medical Supplies
• Coverage is provided for Medically Necessary Nondurable Supplies dispensed and used by a Physician or Health Care Practitioner in conjunction with treatment of the covered individual.
• Coverage is provided for Medically Necessary home/personal use:
  • Sterile surgical supplies used immediately after surgery.
  • Supplies needed to operate or use covered Durable Medical Equipment or Corrective Appliances.
  • Supplies needed for use by skilled home health or home infusion personnel, but only during the course of their required services.
  • Dialysis supplies.
  • Colostomy and ostomy supplies and/or urinary catheter supplies.
  • Diabetic supplies (e.g., insulin syringes, test strips, lancets) are covered under the Prescription Drug Program. Necessary diabetic insulin pump supplies (if not available under the Prescription Drug Program) are payable under this benefit.
	• To determine what Nondurable Medical Supplies are covered, see the definition of "Nondurable Supplies" in the Glossary Chapter.	After Deductible met, Plan pays 80%.	After Deductible met, Plan pays 50%.

Nutritional Supplemental Infusions • Nutritional supplemental infusions (such as tube feedings to sustain life) are payable, based on the patient's diagnosis and medical condition, when required to sustain life or maintain a reasonable level of good health as determined by the Claims Administrator.	• **Preauthorization is required for nutritional supplemental infusions** by calling the Preauthorization Program whose contact information is listed on the Quick Reference Chart in the front of this document. See also Chapter 4 for details.	After Deductible met, Plan pays 80%.	After Deductible met, Plan pays 50%.

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE BRONZE MEDICAL PLAN			
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BENEFIT DESCRIPTION	**EXPLANATIONS AND LIMITATIONS OF BENEFITS**	**PPO In-Network**	**Out-of-Network**
Oral and Craniofacial Services • Medically Necessary maxillofacial surgical procedures are covered when performed by a Physician (M.D.) or qualified oral and/or maxillofacial surgeon. • Accidental Injury to Teeth/Jaw. • Oral and/or Craniofacial Surgery. • Charges by an oral maxillofacial surgeon for reduction of facial bone fractures, removal of jaw tumors, treatment of jaw dislocations, treatment of facial and oral wounds or lacerations or infections (cellulitis), and removal of cysts or tumors of the jaws/facial bones. See also the exclusions related to Dental Services in the Exclusions Chapter 6.	• **Treatment of Accidental Injuries to the Teeth**: This medical plan will pay for treatment of certain accidental injuries to the teeth and jaws when, in the opinion of the Plan Administrator or its Delegate, all of the following conditions are met: a) The accidental injury must have been caused by an extrinsic/external force and not an intrinsic force (such as the force of chewing or biting); and b) The dental treatment to be payable is the most cost-effective option that meets acceptable standards of professional dental practice; and c) The dental treatment will return the person's teeth to their pre-injury level of health and function. The dental treatment provider is encouraged to seek pre-treatment approval from the Plan Administrator for dental work. Injury to Teeth means an injury to the teeth caused by trauma from an external source, and does not include an injury to the teeth caused by any intrinsic force, such as the force of biting or chewing. • Oral or craniofacial surgery is covered for certain Medically Necessary reconstructive purposes, but not for Cosmetic purposes. • No coverage for treatment or Surgery related to Temporomandibular Joint (TMJ/TMD) dysfunction or syndrome. Other than the services noted as covered in this row, the Plan does not cover other dental services, including but not limited to removal of teeth including removal of wisdom teeth, endodontics such as root canal, gingivectomy, procedures in preparation for future dental work or dental implant (such as sinus lift, soft tissue graft, bone graft/replacement), treatment or prevention of Temporomandibular Joint dysfunction/syndrome, or orthognathic Surgery for treatment of aesthetic malposition of the bones of the jaw. See also the exclusions related to Dental Services in the Exclusions Chapter 6.	Physician services payable according to the Physician services row of this Schedule.	Physician services payable according to the Physician services row of this Schedule.
Osteopathic Manipulation	• See the Spinal Manipulation row in this Schedule.		

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE BRONZE MEDICAL PLAN

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of-Network
Outpatient (Ambulatory) Surgery Facility/Center • Ambulatory (Outpatient) Surgical Facility/Center (e.g. ambulatory center, surgicenter, same day Surgery, outpatient Surgery). • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in an outpatient (Ambulatory) Surgery facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters.	• **Preauthorization surgical procedures where the surgeon's fee is expected to exceed $1,500 is recommended** by calling the Preauthorization Program whose contact information is listed on the Quick Reference Chart in the front of this document. See also Chapter 4 for details. • Under certain circumstances the Bronze Plan will pay for the facility fees and anesthesia associated with Medically Necessary dental services covered by a Dental Plan if the Bronze Plan Claims Administrator determines that Hospitalization or outpatient Surgery facility care is Medically Necessary to safeguard the health of the patient during performance of dental services. The medical plan does not cover the dental professional fees or dental products/supplies for the dental service that occurs at a Hospital or outpatient Surgery facility.	After Deductible met, Plan pays 80%	After Deductible met, Plan pays 50% of the surgical facility fee up to a maximum Plan payment of up to $5,000 per operative session for Surgery-related services and supplies and up to $3,500 for other outpatient department services and supplies per episode of treatment.
Prescription Drugs (Outpatient)	• See the Drug row for information on outpatient retail and mail order prescription medication.		
Preventive Care	• See the Wellness rows in this Schedule.		
Prosthetic Devices	• See the Corrective Appliances row in this Schedule.		
Radiology (X-Ray), Nuclear Medicine, Imaging Studies and Radiation Therapy Services (Outpatient) • Radiology refers to the branch of medicine using x-rays, radiopharmaceuticals (like radioisotopes, intravenous dye or contrast materials), magnetic resonance and ultrasound to create images (pictures) of the body that are used to help in the diagnosis and treatment of disease or injury. • Common radiology services include chest x-ray, abdomen/kidney x-ray, spine x-ray, CT/MRI/PET and bone scan, ultrasound, angiography, mammogram, fluoroscopy, and bone densitometry. • Technical and professional fees associated with diagnostic and curative radiology services, including radiation therapy.	• **Preauthorization of complex diagnostic imaging tests such as MRI's, PET and CAT/CT scans is required** by calling the Preauthorization Program whose contact information is listed on the Quick Reference Chart in the front of this document. See also Chapter 4 for details. • Covered only when ordered by a Physician or Health Care Practitioner. • Some Radiology procedures (such as a screening mammogram) are covered under the Preventive/Wellness Programs described in this Schedule.	After Deductible met, Plan pays 80%	After Deductible met, Plan pays 50%

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE BRONZE MEDICAL PLAN This chart explains the benefits payable by the Plan. See also the Exclusions and Glossary Chapters of this document for important information. All benefits are subject to the Deductible except where noted. *IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Glossary Chapter, and could result in Balance Billing to you.			
BENEFIT DESCRIPTION	**EXPLANATIONS AND LIMITATIONS OF BENEFITS**	**PPO In-Network**	**Out-of-Network**

Reconstructive Services and Breast Reconstruction After Mastectomy
• This Plan complies with the **Women's Health and Cancer Rights Act** (WHCRA) that indicates that for any covered individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, including:
  • reconstruction of the breast on which the mastectomy was performed;
  • surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  • prostheses and physical complications for all stages of mastectomy, including lymphedemas.
These benefits are covered applying the same cost-sharing as is relevant to other medical/surgical plan benefits.
• Reconstructive Surgery only if such procedures or treatment are intended to improve bodily function, repair a functional defect and/or to correct deformity or disfigurement resulting from disease, infection, trauma, congenital anomaly or covered Surgery.
	• The Plan covers replacement external breast prostheses and mastectomy bras when Medically Necessary.
	• See the exclusions related to Cosmetic Services (including Reconstructive Surgery) in the Exclusions Chapter 6. Most Cosmetic and Dental (including Orthognathic) services are excluded from coverage.
		After Deductible met, Plan pays 80%	After Deductible met, Plan pays 50%

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE BRONZE MEDICAL PLAN

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of-Network
Rehabilitation Services: (Physical, Occupational & Speech Therapy) • Short term **active, progressive** Rehabilitation Services (Occupational, Physical, or Speech Therapy) performed by licensed or duly qualified therapists as ordered by a Physician. • Inpatient Rehabilitation Services in an acute Hospital, rehabilitation unit or facility or Skilled Nursing Facility for short term, **active, progressive** Rehabilitation Services **that cannot be provided in an outpatient or home setting.** • All benefits are subject to the limitations and the Maximum Plan Benefits shown in the Explanations and Limitations column. • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in an inpatient rehabilitation facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters.	• **Preauthorization of inpatient rehabilitation admissions and outpatient physical, occupational and speech therapy is required** by calling the Preauthorization Program, whose contact information is listed on the Quick Reference Chart in the front of this document. See also Chapter 4 for details. • Rehabilitation services, including Habilitation services, are covered when ordered by a Physician. The therapy must be rendered for the purpose of physical restoration of a physical disability for which there is a reasonable expectation of significant improvement in the status of that disability as determined by the Plan. Services must be certified by the Physician as Medically Necessary for the improvement of the patient's condition through short-term care. • **Inpatient Rehabilitation Services:** benefit maximum is 30 days per Calendar Year. • **Outpatient Rehabilitation Services:** a) **Physical Therapy:** benefit maximum is 20 sessions per Calendar Year. Additional sessions beyond this benefit maximum are available if additional therapy is preauthorized and determined as Medically Necessary by the Plan Administrator or its designee. b) **Occupational Therapy:** benefit maximum is 20 sessions per Calendar Year. Additional sessions beyond this benefit maximum are available if additional therapy is preauthorized and determined as Medically Necessary by the Plan Administrator or its designee. c) **Speech Therapy:** benefit maximum is 130 sessions per lifetime (whether or not there has been an interruption in coverage or change in eligibility status). To be covered, the speech therapy must be Medically Necessary to restore speech that was completely or severely impaired as a result of an accidental injury or illness, or develop speech in individuals whose inability to speak is the result of a hearing disorder. Speech therapy for minor speech impediments or for any other reason other than as outlined above is not covered. Not more than one visit is covered per day. • No coverage for long term maintenance therapy or group exercise programs. See specific exclusions relating to Rehabilitation in the Exclusions Chapter 6 and the definition of Active, Passive and Maintenance Rehabilitation in the Glossary Chapter.	After Deductible met, Plan pays 80%.	After Deductible met, Plan pays 50%.

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE BRONZE MEDICAL PLAN

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of-Network
Sexually Transmitted Infection Testing/Screening • The Plan will pay for tests/screenings for sexually transmitted infections (STIs), including the administration of such tests and the associated office visit.	• Covered only when ordered by a Physician or Health Care Practitioner	No charge, Deductible does not apply.	After Deductible met, Plan pays 50%.
Skilled Nursing Facility (SNF) or Subacute Facility • Skilled Nursing Facility (SNF). • Subacute Care Facility, also called Long Term Acute Care (LTAC) Facility. • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in a Skilled Nursing Facility or subacute facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters.	• **Preauthorization of a Skilled Nursing Facility admission is required** by calling the Preauthorization Program whose contact information is listed on the Quick Reference Chart in the front of this document. See also Chapter 4 for details. • Services must be ordered by a Physician. • **Skilled Nursing Facility confinement or Subacute care facility confinement is** payable up to **180 days per period of confinement**. All confinements will be considered to have occurred during one period of confinement unless the confinements were due to entirely unrelated causes, or, complete recovery from the injury or sickness causing the previous confinement has taken place, or, in the case of an employee, the confinements are separated by a return to work for at least one regular working day, or, the confinements are separated by a period of 90 consecutive days. • Benefits are payable if an Eligible Individual has been confined in an acute care (general) Hospital for at least 5 consecutive days and is then immediately transferred to a Skilled Nursing Facility (also referred to as an Extended Care Facility) for additional treatment or rehabilitation (this does not include Custodial Care).	No charge, Deductible does not apply for the first 30 days, thereafter, after Deductible met, Plan pays 80% for the next 150 days.	No charge, Deductible does not apply for the first 30 days, thereafter, after Deductible met, Plan pays 80% for the next 150 days.
Smoking/Tobacco Cessation Benefits • This benefit can be used to help with nicotine addiction (to stop smoking or stop chewing tobacco). • The Behavioral Health benefits of this Plan may be used for outpatient visits for smoking/tobacco cessation counseling. • See the Behavioral Health row of this Schedule.	• Coverage is extended for over the counter or prescription tobacco cessation products (such as nicotine gum or patches) or counseling (by a licensed counselor) intended to assist an individual to stop smoking or using tobacco products. The Drugs are payable through the Prescription Drug Program at no charge. Present a written prescription from a network Physician for over the counter or prescription tobacco cessation products to the retail pharmacist. See the Drug row in this Schedule. • The Plan covers: a) Screening for tobacco use; and, b) For those who use tobacco products, at least two (2) tobacco cessation attempts per year. Cessation attempt includes coverage for: ◦ Four (4) tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling with a licensed counselor) without prior authorization; and ◦ All FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.	Tobacco cessation Counseling and medication: No charge. Deductible does not apply.	Tobacco cessation Counseling and medication: Not covered.

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE BRONZE MEDICAL PLAN			
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BENEFIT DESCRIPTION	**EXPLANATIONS AND LIMITATIONS OF BENEFITS**	**PPO In-Network**	**Out-of-Network**
Spinal Manipulation Services • Spinal Manipulation Services (from a Physician – MD or DO, or Chiropractor) including related ancillary services (e.g., office visit, x-rays, is subject to the Annual Maximum Plan Benefit shown in the Explanations and Limitations column to the right.	• **Spinal Manipulation by a Chiropractor, MD, or Doctor of Osteopathy (DO):** maximum benefit is 24 visits per person per Calendar Year. Not more than one visit is covered per day. • Spinal manipulation treatment does not accumulate to meet the Plan's annual Out-of-Pocket limit.	Spinal Manipulation by a Chiropractor: After Deductible met, Plan pays 100% up to a maximum of $10 for each visit. Spinal Manipulation by a MD or DO: After Deductible met Plan pays 80%.	Spinal Manipulation by a Chiropractor: After Deductible met, Plan pays 100% up to a maximum of $10 for each visit. Spinal Manipulation by a MD or DO: After Deductible met Plan pays 50%.
Substance Abuse/Substance Use Treatment	• See the Behavioral Health row of this Schedule.		
Tobacco Cessation Benefits	• See the Smoking/Tobacco Cessation Benefits row of this Schedule.		

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE BRONZE MEDICAL PLAN

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BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of-Network

Transplants (Organ and Tissue)
• Effective 1-1-19, coverage is provided for eligible services directly related to **Medically Necessary and non-Experimental transplants of human organs or tissue**, including but not limited to, bone marrow, peripheral stem cells, cornea, heart, heart/lung, intestine, islet tissue, kidney, kidney/pancreas, liver, liver/kidney, lung(s), pancreas, bone, tendons or skin, along with the facility and professional services, FDA approved Drugs, and Medically Necessary equipment and supplies.
• **Organ/tissue Procurement** is payable. Procurement includes expenses to find the donated organ/tissue (donor search fees), tests on the potential organ/tissue for compatibility, Surgery/procedures to remove the organ/tissue, preservation of the organ/tissue until it can be transplanted and transportation fees to deliver the organ/tissue to the patient/recipient.
• Reasonable and necessary medical expenses incurred by a donor who **is covered** by this Plan, are payable without any cost-sharing applicable to those expenses.
• Reasonable and necessary medical expenses incurred by a donor who **is not covered** by this Plan, are payable without any cost-sharing applicable to those expenses, **but only to the extent the donor is not covered by the donor's own insurance or health care plan**.
• Transplant related travel benefits are available for the patient and one family member or companion, when the approved transplant must occur 75 or more miles from the patient's residence, as outlined in the Explanations column to the right.
	• **Transplant services, including pre-transplant workup tests and transplant-related travel, require preauthorization** by calling the Preauthorization Program, whose contact information is listed on the Quick Reference Chart in the front of this document. See also Chapter 4 for details.
	• **Transplant Related Travel Benefit:** Certain travel expenses incurred in connection with an approved transplant performed at an approved health care facility that is **75 miles or more** from the recipient's or donor's place of residence are covered, **provided the expenses are preauthorized by the medical plan claims administrator**.
	  • **Maximum payment will not exceed $10,000/transplant for travel expenses incurred by the recipient and one companion* or the donor.**
	  • *Note: When the member recipient is under 18 years of age, this benefit will apply to the recipient and two caregiver companions.
	  • Ground transportation to and from the approved health care facility when it is **75 miles or more** from the recipient's or donor's place of residence. **Coach airfare** to and from the approved health care facility when the designated facility is 300 miles or more from the recipient's or donor's residence.
	  • Lodging, limited to **one room, double occupancy**. Other reasonable expenses. Benefits for lodging and ground transportation provided up to the current limits set by the Internal Revenue Code.
	  • The annual Deductible will not apply, and no Copayments will be required for transplant travel expenses preauthorized in advance by the claims administrator.
	  • Expenses incurred for the **following are not covered**: tobacco, alcohol, Drugs, meal expenses, interim visits to a medical care facility while waiting for the actual transplant procedure; travel expenses for a companion and/or caregiver for a transplant donor; return visits for a transplant donor for treatment of a condition found during the evaluation; rental cars; buses, taxis or shuttle services; and mileage within the city in which the medical transplant facility is located.
	  • Details regarding reimbursement can be obtained by calling the member services number on your identification card. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.
	• See the specific exclusions related to Experimental and Investigational Services and Transplants in the Exclusions Chapter 6.
	• For Plan participants who serve as a donor, donor expenses are not payable unless the person who receives the donated organ/tissue is a person covered by this Plan. Expenses related to non-human (Xenografted) organ and/or tissue transplants or implants are excluded, except the Plan covers heart valves.
		Physician services payable according to the Physician services row of this Schedule.
		
		Hospital services payable according to the Hospital row in this Schedule.
			Physician services payable according to the Physician services row of this Schedule.
			
			Hospital services payable according to the Hospital row in this Schedule.

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE BRONZE MEDICAL PLAN

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

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of-Network
Weight Management Services • As a **preventive counseling benefit** in compliance with the Affordable Care Act (ACA), the Plan covers (for adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors) **intensive behavioral counseling** interventions to promote a healthful diet and physical activity for CVD prevention. For children age 6 years and older with obesity, the Plan covers Physician prescribed intensive behavioral counseling interventions to promote improvement in weight status at the visit frequency recommended by the child's Network pediatrician. See the Wellness rows and Dietitian rows for more details. • Weight loss Surgery (e.g. bariatric Surgery) is covered as explained to the right.	Effective 4-1-19, coverage is provided for a surgical procedure to promote weight loss (e.g. bariatric Surgery) when ALL of the following criteria are met: •Surgery must be considered Medically Necessary and not be Experimental/Investigational/unproven as determined by the Plan Administrator or its Delegate. •**Weight loss (bariatric) Surgery requires preauthorization** by calling the Preauthorization Program whose contact information is listed on the Quick Reference Chart in the front of this document. See also Chapter 4 for details. •For coverage: •Individual is morbidly obese with a body mass index (BMI) of 40 or greater, or a BMI of 35 or greater with at least two comorbidities such as diabetes or cardiopulmonary condition. •Recommendation is received for Surgery from the patient's primary care Physician. •Patient is approved under the requirements of the Plan's preauthorization process. •Evidence of the patient's active participation in and documentation of prior non-surgical methods of weight loss. •The individual is 18 years of age or older. •**Coverage is provided by Network Health Care Providers only**. No bariatric Surgery coverage for Non-Network surgeons or facilities. •There is a Copayment for bariatric Surgery. The Copay is generally payable to the Physician, not the facility. •**One bariatric surgical procedure is payable per person per lifetime**. •No coverage for skin reduction procedures/surgery related to weight loss.	After a $2,500 Copay per Surgery per person, Physician services payable according to the Physician services row of this Schedule. Hospital services payable according to the Hospital row in this Schedule.	Not covered.

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE BRONZE MEDICAL PLAN

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

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of-Network
Wellness (Preventive) Program Well Child Examinations and Immunizations • Outpatient newborn and well child visits and routine childhood immunizations that are FDA approved and in accordance with the Centers for Disease Control & Prevention (CDC) recommendations for children in the US, such as DPT, Polio, MMR, HIB, hepatitis, chickenpox, tetanus, influenza (flu) vaccine, HPV (e.g. Gardasil, Cervarix), etc. • **Immunizations/Vaccinations Available from the Retail Pharmacy**: The Plan covers immunizations obtained from a network retail pharmacy or during a network Physician office visit. • The wellness/Preventive Services payable by this Plan are designed to comply with Affordable Care Act (ACA) regulations as outlined to the right. • Preventive services are payable without regard to gender assigned at birth, or current gender status. • For children age 6 years and older with obesity, Plan covers Physician prescribed **intensive behavioral counseling** interventions to promote improvement in weight status at the visit frequency recommended by the child's Network pediatrician. • When performed in primary practices, **topical fluoride** varnish to the primary teeth of children is payable through age 5 years. • See page 62 for information on payment of ACA-mandated Drugs. • If there is no network provider who can provide the Affordable Care Act (ACA) required wellness service, then Plan will cover the service when performed by an out-of-network provider without cost-sharing.	The wellness/Preventive Services payable by this Plan are designed to comply with Affordable Care Act (ACA) regulations and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), Bright Futures and the Centers for Disease Control & Prevention (CDC). These websites (periodically updated) list the types of payable Preventive Services, including immunizations: https://www.healthcare.gov/what-are-my-preventive-care-benefits/ with more details at http://www.cdc.gov/vaccines/schedules/hcp/index.html, http://www.hrsa.gov/womensguidelines/ and https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/ (A and B rated recommendations). • In addition to the wellness services listed on the websites above, the Plan will pay for these wellness services: well child office visits, well woman office visits, female contraceptives, and certain over-the-counter Drugs. • When both Preventive Services and diagnostic or therapeutic services occur at the same visit, you pay the cost share (e.g. Deductible, Copay, Coinsurance) for the diagnostic or therapeutic services but not for the Preventive Services. When a preventive visit turns into a diagnostic or therapeutic service in the same visit, then cost-sharing (e.g. Deductible, Copay, Coinsurance) will apply to the diagnostic or therapeutic services provided. • Preventive services are considered for payment when billed under the appropriate Preventive Service codes (benefit adjudication depends on accurate claim coding by the providers). If the billing for a wellness service is submitted to the claims administrator with a diagnosis code other than "wellness," claims will be processed under the Plan's usual cost-sharing including Deductible/Copay/Coinsurance. • Services not covered under the wellness/preventive benefit may be covered under another portion of the medical plan. Additional diagnostic services that are Medically Necessary because of the patient's medical diagnosis are covered, subject to the Plan's Deductibles, Coinsurance or Copayments, and all other Plan provisions. • If an Affordable Care Act (ACA) Preventive Service recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the Plan will use reasonable medical management techniques (such as age, frequency, location, method) to determine coverage parameters. The frequency for Affordable Care Act (ACA) Preventive Service recommendation is specified in these websites: https://www.healthcare.gov/what-are-my-preventive-care-benefits/, http://www.cdc.gov/vaccines/schedules/hcp/index.html, http://www.hrsa.gov/womensguidelines/, and http://www.uspreventiveservicestaskforce.org/BrowseRec/Index. The frequency of preventive visits for children is payable in accordance with the "Recommendations for Preventive Pediatric Health Care" from Bright Futures/American Academy of Pediatrics, updated periodically, (website for the schedule is: https://www.aap.org/en-us/Documents/periodicity_schedule.pdf). Note that for females, in accordance with the Affordable Care Act (ACA), the Plan will pay both a preventive office visit and a well woman office visit in a Calendar Year. • Where the information in this document conflicts with newly released Affordable Care Act regulations affecting Preventive Care coverage, this Plan will comply with the new requirements on the date required. • No coverage for immunizations/vaccines specifically required for travel or work (which are not otherwise CDC-recommended in the US).	No charge, Deductible does not apply.	After Deductible met, Plan pays 50%.

Chapter 5: SCHEDULE OF MEDICAL BENEFITS FOR THE BRONZE MEDICAL PLAN

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

BENEFIT DESCRIPTION	EXPLANATIONS AND LIMITATIONS OF BENEFITS	PPO In-Network	Out-of-Network
Wellness (Preventive) Program: Adult Health Maintenance Examinations **(Age 18 & up)** • The wellness/Preventive Services payable by this Plan are designed to comply with Affordable Care Act (ACA) regulations as outlined to the right. Certain prescription and non-Prescription Drugs, required to be covered in compliance with Affordable Care Act (ACA), are available through the Outpatient Prescription Drug program. Health care billed as wellness is payable for the following services: • **Annual routine preventive health exam**. Women are permitted to receive an annual routine gynecology (GYN) health exam in addition to the annual routine preventive health exam. • **Adult immunizations** that are FDA approved and in accordance with the Centers for Disease Control & Prevention (CDC) recommendations for adults in the US, such as annual flu shot, HPV vaccine (e.g. Gardasil, Cervarix), shingles vaccine, etc. • **Colon cancer screening** is payable for adults age 50 and older, including fecal occult blood test annually, stool DNA testing like Cologuard annually, AND screening colonoscopy (including anesthesia services) every 10 years, or any of these tests once every five (5) years: virtual screening colonoscopy, double contract barium enema, or flexible sigmoidoscopy. No charge for a specialist pre-procedure consultation, bowel prep medication used prior to a screening colonoscopy, anesthesia services, or the lab charges for analysis of polyps removed during a screening colonoscopy. • **Screening Mammogram** every other year for females age 50-74. • As a preventive counseling benefit in compliance with Affordable Care Act (ACA), the Plan covers the following services for adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors: **intensive behavioral counseling** interventions to promote a healthful diet and physical activity for CVD prevention. • See page 62 for information on ACA-mandated Drugs.	The wellness/Preventive Services payable by this Plan are designed to comply with Affordable Care Act (ACA) regulations and the current A and B recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), Bright Futures, & the Centers for Disease Control & Prevention (CDC). These websites (periodically updated) list the types of payable Preventive Services (such as immunizations, mammogram, pap smear, screening colonoscopy with anesthesia and colon polyp removal): https://www.healthcare.gov/what-are-my-preventive-care-benefits with more details at: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/, http://www.cdc.gov/vaccines/schedules/hcp/index.html, and http://www.hrsa.gov/womensguidelines/. • In accordance with the Affordable Care Act (ACA), certain additional Preventive Care expenses are payable for all covered females as listed on the government websites at http://www.hrsa.gov/womensguidelines/ or https://www.healthcare.gov/what-are-my-preventive-care-benefits including but not limited to well woman office visits, screening for gestational diabetes, Genetic Counseling for females at risk for breast cancer, BRCA breast cancer gene test, HPV testing at least every 3 years starting at age 30, counseling on sexually transmitted infections, annual HIV screening and counseling, breastfeeding equipment and supplies needed to operate equipment, lactation support. See also the Durable Medical Equipment and Maternity Services rows in this Schedule. • If a preventive item or service is billed separately from an office visit, then the Plan will impose cost-sharing with respect to the office visit. If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is the delivery of a Preventive Service, then the Plan will pay 100% for the office visit. If the Preventive Service is not billed separately from the office visit, and the primary purpose of the office visit is not the delivery of a Preventive Service, then the Plan will impose cost-sharing for the office visit. For example, if a person has a cholesterol screening test during an office visit, and the doctor bills for the office visit and separately for the cholesterol screening lab test, the Plan will charge cost-sharing (e.g. Deductible, Copay, Coinsurance) for the office visit but not for the cholesterol screening lab test. • Preventive services are considered for payment when billed under the appropriate Preventive Service codes (benefit adjudication depends on accurate provider claim coding). If the billing for a Preventive Service is submitted to the claims administrator with a diagnosis code other than "wellness," claims may be processed under the Plan's usual non-preventive cost-sharing. Services not covered under the preventive benefit may be covered under another portion of the medical plan. Additional diagnostic services that are Medically Necessary because of the patient's medical diagnosis may be covered subject to the Plan's Deductibles, Coinsurance or Copayments, and all other Plan provisions. • If an Affordable Care Act (ACA) Preventive Service recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the Plan will use reasonable medical management techniques (such as age, frequency, location, method) to determine coverage parameters. If there is no Network provider who can provide the Affordable Care Act (ACA) required wellness service, then the Plan will cover the service when performed by an out-of-network provider without cost-sharing. • Where the information in this document conflicts with newly released Affordable Care Act regulations affecting Preventive Care coverage, this Plan will comply with the new requirements on the date required. Preventive services are payable without regard to gender assigned at birth, or current gender status. • No coverage for immunizations/vaccines specifically required for travel or work (which are not otherwise CDC-recommended in the US).	No charge, Deductible does not apply.	After Deductible met, Plan pays 50%.

CARPENTERS SOUTHWEST ADMINISTRATIVE CORPORATION

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SUMMARY OF MATERIAL MODIFICATIONS

IMPORTANT NOTICE

MARCH 2021

To: **PARTICIPANTS IN THE SOUTHWEST CARPENTERS HEALTH & WELFARE PLAN**

Re: **EXTENSION OF DEADLINES DUE TO COVID-19 PANDEMIC**

As you may recall, certain employee benefit plan deadlines have been suspended from March 1, 2020 until sixty (60) days after the announced end of the National Emergency that was declared by the President on March 13, 2020 (referred to as the "Outbreak Period").

By federal law, the suspension of deadlines during the Outbreak Period is limited to a maximum of one year from the deadline that normally would have applied or, if earlier, until 60 days after the announced end of the National Emergency (defined in this notice as the "Suspension Period"). Following the end of the period in which deadlines are suspended, participants will be permitted the number of days defined by the Plan to take action with respect to the following deadlines:

- The 60-day period to elect COBRA;
- The 45-day period to make an initial COBRA premium payment and the 30-day deadline to make COBRA premium payments for subsequent in months of COBRA;
- The deadline for plan administrators to provide the COBRA election notice;
- The 90-day HIPAA special enrollment deadlines to request enrollment in this Trust Fund following a special enrollment event (i.e., marriage, birth, adoption or placement for adoption of a child, or loss of other health coverage);
- The 90-day deadline for filing a claim, and the 180-day deadline to file an appeal for benefits or a request for an external review of an adverse benefits determination; and
- The 45-day deadline to provide additional information to support a claim for Long-Term Disability benefits.
- The 180-day deadline to file an appeal from a denial of Long-Term Disability benefits.

- The 15-day deadline for a Long-Term Disability recipient to give notice of their recovery from the disability or the discontinuance of Social Security Disability.
- The 90-day deadline to submit a Social Security Disability Award in connection with an application to receive Supplemental Long-Term Monthly Disability Benefits.
- The 2-year deadline to submit a Social Security Disability Award in connection with an application to receive the Auxiliary Disability Benefit.

The following examples illustrate how the deadlines will resume after the end of the Suspension Period.

I. HIPAA special enrollment timeframes

The usual deadline to request enrollment in this Trust Fund following a special enrollment event (i.e., marriage, birth, adoption or placement for adoption of a child, or loss of other health coverage) has been suspended during the Suspension Period and will restart on the earlier of one year following the date of the special enrollment event or 60 days following the announced end of the National Emergency. Note that the time to submit a request for special enrollment of a new spouse or child was 31 days after the marriage or birth prior to June 1, 2020. The 31-day special enrollment period was amended to 90 days effective June 1, 2020.

Example 1: *If an employee is married or has a new child on June 1, 2020, the employee will have90 days after the end of the Suspension Period to submit a request for special enrollment of the new spouse or child. Since the Suspension Period will end on May 31, 2021, the request to add the new child or spouse will be deemed timely if it is filed with the Administrative Office by August 29, 2021 (90 days after the end of the Suspension Period). In this example, if a timely request is made by August 29, 2021, the new dependent will be eligible from the date of marriage, birth, or adoption (March 1, 2020).*

Example 2: *If an employee has a new child on February 15, 2020, then 15 days in February is subtracted from the 31-day timeframe to enroll the child. The employee will have until 15 days after the end of the Suspension Period to submit a request for special enrollment of the new child. Since the Suspension Period will end on February 28, 2021 for this employee, the request to add the new child will be deemed timely if it is filed with the Administrative Office by March 16, 2021 (16 days after the end of the Suspension Period). In this example, if a timely request is made by March 16, 2021, the new dependent child will be eligible from the date of birth or adoption (February 15, 2020).*

Example 3: If an employee is married or has a new child on January 1, 2021, the employee will have until 90 days after the earlier of the end of the Outbreak Period or one year from the date of marriage, birth, or adoption to submit a request for special enrollment of the new spouse or child. If the National Emergency is not yet ended by December 31, 2021, the request to add the new child or spouse will be deemed timely if it is filed with the Administrative Office by March 31, 2022 (90 days after the end of the one year period following marriage, birth, or adoption). In this example, if a timely

request is made by March 31, 2022, the new dependent will be eligible from the date of marriage, birth, or adoption (January 1, 2021). However, if the National Emergency ends on June 1, 2021, the Outbreak Period will end on July 31, 2021 (the 60th day following the end of the National Emergency), and the request to add the new child or spouse will be deemed timely if it is filed with the Administrative Office by October 30, 2021 (90 days after the end of the Outbreak Period).

II. **Benefit claims and appeals**

The 90-day deadline to submit claims has been suspended during the Suspension Period, and will restart the earlier of one year following the date the claim was incurred or 60 days following the announced end of the National Emergency.

Example 1: *If a claim was incurred on March 1, 2020, the deadline to file the claim will be May 29, 2021 (the 90th day after February 28, 2021).*

Example 2: If a claim was incurred on January 1, 2021 and the National Emergency has not yet ended by December 31, 2021, the deadline to file the claim will be March 31, 2022 (the 90th day after December 31, 2021). However, if the end of the National Emergency were declared over on June 1, 2021, the Outbreak Period will end on July 31, 2021. In that case, the deadline to file the claim will be October 29, 2021 (the 90th day after July 31, 2021).

Likewise, the 180-day deadline to file an appeal from a denied claim has been suspended during the Suspension Period and will restart on the earlier of one year following the date you receive notice of a claim denial or 60 days following the announced end of the National Emergency.

Example 3: If the notice of denial is received on March 1, 2020, the deadline to file an appeal is 180 days after the end of the Suspension Period. Since the Suspension Period will end on February 28, 2021, the deadline to file an appeal will be August 27, 2021 (the 180th day after February 28, 2021).

Example 4: If the denial was received on February 1, 2020, then 29 days in February is subtracted from the 180-day timeframe to file an appeal. However, the Suspension Period does not diminish the remaining 151 days to file an appeal. The remaining 151 days won't start to run after February 28, 2021. Thus, the deadline to file an appeal will be July 29, 2021 (151 days after February 28, 2021).

Example 5: If the notice of denial is received on January 1, 2021, the deadline to file an appeal is 180 days after the end of the earlier of the end of the Outbreak Period or 1 year from the notice of denial. If the National Emergency is not yet ended by December 31, 2021, a filed appeal will be deemed timely if it is filed with the Administrative Office by June 29, 2022 (180 days after the end of the one year period following the notice of denial). However, if the National Emergency ends on June 1, 2021, the Outbreak Period will end on July 31, 2021, a filed appeal will be deemed timely if it is filed with the Administrative Office by January 27, 2022 (180 days after the end of the Outbreak Period).

III. COBRA notice, election and payment deadlines

The deadlines for electing COBRA coverage, paying COBRA premiums, and for notifying the health plan of a Qualifying Event that is a divorce, separation, loss of dependent status or a disability have been suspended during the Suspension Period and will restart on the earlier of one year following the date you receive notice of a claim denial or 60 days following the announced end of the National Emergency.

Example 1: *If an employee has a COBRA qualifying event (a reduction of hours or a termination) and wishes to elect COBRA coverage, the normal 60-day election period is not diminished by the Suspension Period. For example, if coverage is lost on March 1, 2020 due to a qualifying event and the COBRA election notice is sent on March 1, 2020, the deadline to elect COBRA will be April 29, 2021 (the 60th day after February 28, 2021).*

The deadline to pay the initial COBRA premium will occur 45 days after COBRA is elected. If the employee elects COBRA on April 29, 2021, the initial COBRA premium is due on June 13, 2021 (45 days after April 29, 2021).

Until the employee elects and pays for coverage the administrative office will inform health care providers that the employee does not currently have coverage but will have coverage retroactively if he elects COBRA coverage and makes timely payment of COBRA premiums covering the months from the COBRA qualifying event. Thus, in the example above, if the employee elects COBRA by April 29, 2021 she will be eligible as of March 1, 2020 as long as she pays COBRA premiums for the months of March 2020 through June 2021 by June 13, 2021. If the employee only pays COBRA premiums for two months, then the Plan would not be obligated to pay for services rendered after April 2020.

Example 2: *If coverage is lost on January 1, 2021 due to a qualifying event and the COBRA election notice is sent on January 1, 2021, the deadline to elect COBRA will be 60 days after the end of the earlier of the end of the Outbreak Period or December 31, 2021. If the National Emergency is not yet ended by December 31, 2021, a COBRA election will be deemed timely if it is filed with the Administrative Office by March 2, 2022 (60 days after the end of the one year period following the notice of qualifying event). However, if the National Emergency ends on June 1, 2021, the Outbreak Period will end on July 31, 2021, a COBRA election will be deemed timely if it is filed with the Administrative Office by September 29, 2021 (60 days after the end of the Outbreak Period).*

The deadline to pay the initial COBRA premium will occur 45 days after COBRA is elected. If the employee elects COBRA on March 2, 2022, the initial COBRA premium is due on April 16, 2022 (45 days after March 2, 2022). If the employee elects COBRA on September 29, 2021, the initial COBRA premium is due on November 13, 2021 (45 days after September 29, 2021).

Until the employee elects and pays for coverage the administrative office will inform health care providers that the employee does not currently have coverage but will have coverage retroactively if he elects COBRA coverage and makes timely payment of COBRA

premiums covering the months from the COBRA qualifying event. Thus, in the examples above, in the event the Outbreak Period has not ended by December 31, 2021, if the employee elects COBRA by March 2, 2022 she will be eligible as of January 1, 2021 as long as she pays COBRA premiums for the months of January 2021 through April 2022 by April 16, 2022. If the employee only pays COBRA premiums for two months, then the Plan would not be obligated to pay for services rendered after February 2021. In the event the Outbreak Period ends on July 31, 2021, if the employee elects COBRA by September 29, 2021 she will be eligible as of January 1, 2021 as long as she pays COBRA premiums for the months of January 2021 through November 2021 by November 13, 2021. If the employee only pays COBRA premiums for two months, then the Plan would not be obligated to pay for services rendered after February 2021.

* * *

Should you have any questions regarding the above changes or need assistance in determining a due date, please contact the Trust Fund Office at (213) 386-8590 or (800) 293-1370.

Aviso a los participantes que hablan Español: Si tiene alguna pregunta tocante este aviso, por favor de comunicarse con la Oficina Administrativa al (213) 386-8590 o (800) 293-1370, donde habrá varios representantes bilingües que le ayudarán.

CARPENTERS SOUTHWEST ADMINISTRATIVE CORPORATION

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To: All Participants Who Are Eligible for Health and Welfare Bronze Plan Benefits

Summary of Material Modifications

September 2020

PARTICIPANT NOTICE

ADMINISTRATIVE OFFICE. This Participant notice will advise you of certain material modifications that will be made to the Southwest Carpenters Health and Welfare Trust Bronze Plan (the Plan). This information is **very important** for you and your eligible dependents. Please take the time to read it carefully.

Aviso a los participantes que hablan español: Si tiene alguna pregunta referente a este aviso o requiere alguna otra información referente a su cobertura de salud, por favor de comunicarse con la oficina administrativa al (213) 386-8590 o (800) 293-1370, donde habrá varios representantes bilingües que le ayudarán.

EMPLOYEE & DEPENDENT ENROLLMENT PROCEDURE CHANGES

Beginning for enrollments on or after June 1, 2020, enrollment procedures under the Health Plans are revised to reflect new timelines for requesting enrollment of newly eligible individuals and eligible dependents and providing supporting documents (proof of dependent status) to the Administrative Office.

If you are a participant who is eligible for coverage under the Plan, then you and your eligible dependents can enroll in the medical plan. As part of the enrollment process, you are required to submit the proper enrollment forms and proof of dependent status. Examples of proof of dependent status include documentation such as certified copies of marriage certificates (for spouses), copies of birth certificates, legal guardianship or court orders (for natural and adopted Dependent children).

Under the existing Plan rules, you were required to submit enrollment forms and dependent documentation to the Administrative Office within 31 days of acquiring a dependent in order for their coverage to become effective by the first day of the month in which you acquired the dependent. This is provided timely payment of premiums is also made.

With the new Plan enrollment rules, if you are establishing initial eligibility you must submit properly completed enrollment forms along with documentation on your Dependents to the Administrative Office. Your health care coverage will be effective the first day of the month in which the completed enrollment forms and proof of dependent status (if applicable) are received in the Administrative Office. If you are enrolling newly acquired dependents, you now have 90 days to submit all required documents (enrollment forms and proof of dependent status) from when you first acquire a dependent due to marriage, birth, legal guardianship or adoption, or a HIPAA special enrollment event. If enrollment forms and supporting documents are received by the Administrative Office within the 90-day deadline, coverage for your dependents will become effective retroactively to the first day of the month in which you acquired the dependents. Note, timely payment of premiums is still required in order for the above effective dates to apply.

For example: *If you get married on January 1st, you will have until March 31st (90 days) to request enrollment for your new spouse and provide supporting documentation (marriage certificate) to the Administrative Office. If you do so, coverage for your spouse will become effective retroactively to January 1st.*

If you fail to request enrollment and/or submit proof of dependent status by the 90-day deadline, then coverage will become effective on the first of the month in which all required documents are received by the Administrative Office.

For example: *If you get married on January 1st but DO NOT request enrollment and provide supporting documentation (marriage certificate) for your dependent spouse until April 15th, coverage will be effective on April 1st (rather than January 1st).*

If you have any questions about these new enrollment procedures, contact the Administrative Office at (800) 293-1370 or (213) 386-8590.

COVERAGE OF DOMESTIC PARTNERS AND DEPENDENT CHILDREN - OFFERED ONLY IN CALIFORNIA

The State of California requires coverage for Domestic Partners in certain circumstances. Therefore, enrolled Participants who reside in the State of California are allowed to enroll their Domestic Partners along with the dependent children of the Domestic Partner starting with this year's Open Enrollment effective January 1, 2021.

The Domestic Partner and their dependent children will be eligible for the same Plan benefits the participant is enrolled in. A Declaration of Domestic Partnership must be registered with the local city, county or state government agency.

Additional information regarding Domestic Partner benefits, dependent eligibility, and required documentation is available from the Administrative Office.

You can obtain a Declaration of Domestic Partnership form (and more information regarding the requirements to establish a Domestic Partnership in California including applicable fees) at the offices of the Secretary of State and in each County Clerk's office. Forms are also available online at **http://www.sos.ca.gov/dpregistry/forms/sf-dp1.pdf.**

* * * * * * *

If you have questions about this notice, visit the Trust's website at **www.carpenterssw.org**. Or, contact the Administrative Office at (800) 293-1370 or (213) 386-8590.

Sincerely,

THE BOARD OF TRUSTEES

In accordance with ERISA reporting requirements, this document serves as your Summary of Material Modifications (SMM) to the Plan and we are advising you of these Plan changes within 60 days of the adoption of the Plan changes. Receipt of this notice does not constitute a determination of your eligibility. If you wish to verify eligibility, or if you have any questions regarding these Plan changes, contact the Administrative Office.

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Please read this notice carefully as certain deadlines affecting COBRA continuation coverage have been extended during the coronavirus national emergency. You and your family members may have a new or extended opportunity to elect and pay for COBRA coverage.

Southwest Carpenters Health and Welfare Trust
EXTENSION OF COBRA DEADLINES DURING CORONAVIRUS OUTBREAK PERIOD
May 2020

Notice to Participants and Family Members Who Have Not Elected COBRA Continuation Coverage or Missed Payments for COBRA Coverage

If you or your family members do not have COBRA coverage because a COBRA election, or payment, was required on or after March 1, 2020, but COBRA was not elected or timely payment was not made, you and your family members may have a new opportunity to elect and pay for COBRA coverage under the extension described in this notice.

If you are eligible for an extension of the deadlines to elect COBRA or make COBRA payments, COBRA continuation coverage will ONLY be provided if a proper COBRA election is sent to the Administrative Office and required COBRA payments are made by the newly extended deadline**.** (See below for details.)

On May 4, 2020, the federal government adopted an emergency Extension Rule that extends certain COBRA deadlines during the coronavirus "Outbreak Period." The Outbreak Period began on March 1, 2020 and unless changed by a further notice from the federal government, it will end 60 days following the announced end of the National Emergency concerning the Novel Coronavirus, or February 28, 2021 – whichever comes first.

The Extension Rule requires that any time that passes during the Outbreak Period does not count against the ordinary deadlines for electing COBRA coverage, for payment of COBRA premiums, or for notifying the health plan of a COBRA Qualifying Event (specifically, notice of a divorce, separation, loss of dependent status, or a disability that can extend COBRA coverage). Thus, for any COBRA deadline described in this notice falling between March 1, 2020 and the end of the Outbreak Period, that deadline is extended to the end of the Outbreak Period plus the number of days of the deadline that passed during the Outbreak Period.

If you or a family member have made a proper COBRA election and COBRA payment during the additional time allowed by the Extension Rule, but payment is not made for all months

of COBRA eligibility by the end of the extension period, coverage will only be provided for the earliest months for which premiums have been paid. The Extension Rule does not provide any additional months of COBRA eligibility. (For example, if you are eligible for a maximum of 18 months of COBRA continuation coverage, that will not change even if the Extension Rule allows you to make some payments for COBRA continuation coverage after that 18-month period).

Examples:

1. Terry lost coverage on December 31, 2019 and received a COBRA election notice on January 20, 2020. Terry did not elect COBRA coverage by March 20, 2020, (the 60-day deadline under the normal COBRA election rules). The 20-day portion of Terry's COBRA election window that falls within the Outbreak Period (March 1-March 20) is not counted. Terry's expired COBRA election period is reinstated and will now end 20 days after the end of the Outbreak Period.

2. John loses coverage due to a reduction of hours and received a COBRA election notice on April 1, 2020. John's COBRA election period would normally end on May 31, 2020, but will now end 60 days after the end of the Outbreak Period.

3. Susan was receiving COBRA coverage through March 2020 and is eligible to continue receiving COBRA coverage through December 2020 (the end of her maximum COBRA period). COBRA premium payments for each month are due on the first of the month, plus a 30-day grace period. Susan made a timely March 2020 COBRA premium payment, but has not made any payments since then. As of August 1, 2020, Susan has made no premium payments for April, May, June or July. For purposes of this example, assume that the Outbreak Period ends on July 31, 2020. With the 30-day grace period for COBRA payments added after the end of the Outbreak Period, Susan's premium payments for those four months (April through July) are all due by August 30, 2020.

    a) The health plan will not pay for any benefits and services retroactively for April through July unless Susan pays the COBRA premium by August 30, 2020.
    b) If Susan only submits payment equivalent to two months' COBRA premiums by August 30, 2020, benefits and services provided in April and May 2020 would be covered, but COBRA eligibility will end May 31, 2020, and she will have no coverage for benefits or services provided after May 31, 2020.
    c) In this example, any COBRA premium payments due August 1, 2020 and later are not extended because they fall outside the Outbreak period, but Susan will have the ordinary grace period of 30 days from the due date to make any such payments.

If you have any questions concerning the information in this announcement, please direct them to the Administrative Office at 213-386-8590 or 800-293-1370, where the staff will be happy to assist you. You may also visit the Trust's website at www.carpenterssw.org.

Aviso a los participantes que hablan español: *Si tiene alguna pregunta tocante este aviso, o requiere alguna otra información tocante a su cobertura de salud, por favor de comunicarse con la oficina administrativa al (213) 386-8590 o (800) 293-1370, donde habrá varios representantes bilingües que le ayudarán.*

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PARTICIPANT NOTICE ABOUT IMPORTANT PLAN CHANGES

May 2020

To: All Active and COBRA Participants of the Southwest Carpenters Health & Welfare and Vacation Trust Plans

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This Participant Notice will advise you of certain material modifications that will be made to the Plan. **This information is VERY IMPORTANT to you and your dependents**. Please take the time to read it carefully.

Suspension of Deadlines During Coronavirus Outbreak Period

This notice explains how new emergency federal rules suspend the Health and Welfare Plan's deadlines for plan participants, beneficiaries, qualified beneficiaries, and claimants to take certain actions.[1] The changes are temporary - they only apply retroactively from March 1 until sixty (60) days following the end of the "National Emergency" that was declared by President Trump on March 13, 2020.

The period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency is referred to as the "Outbreak Period." The normal deadlines to enroll during a special enrollment period, to file claims and appeals, and make COBRA elections and pay COBRA premiums are suspended during the Outbreak Period and will not start to run again until after the Outbreak Period ends.

Special Enrollment Timeframes (Applies to Health & Welfare Plan Only) – The usual 30-day deadline to request enrollment in this Trust Fund following a special enrollment event (i.e., marriage, birth, adoption or placement for adoption of a child, or loss of other health coverage) is suspended during the Outbreak Period.

Example 1: If a plan participant is married or has a new child on March 1, 2020, the participant will have until 60 days after the end of the National Emergency to submit a request for special enrollment of the new spouse or child. If the National Emergency ends on June 1, 2020, the Outbreak Period will end on July 31, 2020 (the 60th day following the end of the National Emergency). The request to add the new child or spouse will be deemed timely if it is filed with the Administrative Office by July 31, 2020. In this example, if a timely request is made by July 31, 2020, the new dependent child will be eligible from the date of birth or adoption (March 1). In the

[1] This communication reflects our current understanding of the Joint IRS/DOL Rule published on May 4, 2020 in the Federal Register.

case of a new spouse, coverage begins the first day of the calendar month following the marriage (April 1).

Example 2: A plan participant who initially declined coverage through this Trust Fund because he or she had health coverage through a spouse's plan, loses eligibility to participate in his or her spouse's plan effective March 31, 2020. If the National Emergency ends on June 1, 2020, the Outbreak Period will end on July 31, 2020 (the 60th day following the end of the National Emergency). The deadline for the plan participant to request enrollment through this Trust is August 30, 2020 (30 days after the end of the Outbreak Period).

Benefit Claims and Appeals (**Applies to both the Health & Welfare and the Vacation Trust Plan)**

The deadline to submit claims is suspended during the Outbreak Period and will not restart until after the Outbreak Period ends. The deadline to appeal a denied claim varies by Plan and type of claim; however, the written notice of claim denial should include the specific deadline that is being extended per this Notice.

Example 1: If a claim was incurred on March 1, 2020 and the National Emergency is declared over on June 1, 2020, the Outbreak Period will end on July 31, 2020. In that case, the deadline to file the claim will be October 29, 2020 (the 90th day after July 31, 2020).

Likewise, the 180-day deadline to file an appeal from a denied claim is suspended during the Outbreak Period and will not restart until after the Outbreak Period ends.

Example 2: If the notice of denial is received on March 1, 2020, the deadline to file an appeal is 180 days after the end of the Outbreak Period. If the Outbreak Period will end on July 31, 2020, the deadline to file an appeal will be January 27, 2021 (the 180th day after July 31, 2020).

Example 3: If the denial was received on February 1, 2020, then 29 days in February is subtracted from the 180-day timeframe to file an appeal. However, the Outbreak Period does not diminish the remaining 151 days to file an appeal. The remaining 151 days won't start to run after July 31, 2020. Thus, the deadline to file an appeal will be December 29, 2020 (151 days after July 31, 2020).

COBRA notice, election and payment deadlines (Applies to Health & Welfare Plan Only) The deadlines for electing COBRA coverage, paying COBRA premiums, and for notifying the health plan of a Qualifying Event that is a divorce, separation, loss of dependent status or a disability, are suspended during the Outbreak Period and will not restart until after the Outbreak Period ends.

Example: If a plan participant has a COBRA qualifying event (a reduction of hours or a termination) and wishes to elect COBRA coverage, the normal 60-day election period is not diminished by the Outbreak Period. For example, if coverage is lost on March 1, 2020 due to a qualifying event and the COBRA election notice is sent on March 1, 2020 and the Outbreak Period ends on July 31, 2020, the deadline to elect COBRA will be September 29, 2020 (the 60th day after July 31, 2020).

The deadline to pay the initial COBRA premium will occur 45 days after COBRA is elected. If the employee elects COBRA on September 29, 2020, the initial COBRA premium is due on November 13, 2020 (45 days after September 29, 2020). The initial COBRA premium due would be from March 1, 2020 through the month of November 2020.

Until the employee elects and pays for coverage, the administrative office will inform health care providers that the employee does not currently have coverage but will have coverage retroactively if he/she elects COBRA coverage and makes timely payment of COBRA premiums covering the

months of service. Thus, in the example above, if the employee elects COBRA by September 29, 2020 he/she will be eligible as of March 1, 2020 as long as he/she pays COBRA premiums for the months of March through November by November 13, 2020. If the employee only pays COBRA premiums for two months, then the Plan would not be obligated to pay for services rendered after April 2020.

Changes in the Schedule of Medical Benefits for the Anthem PPO Medical Plan (Chapter 5 of the Southwest Carpenters Health & Welfare Trust Summary Plan Description)

Marriage or Family Counseling

Marriage or Family Counseling will be covered under Behavioral Health Services up to a maximum of 12 sessions per plan participant, per year.

Spinal Manipulation

Spinal Manipulation Services performed by a licensed Chiropractor will have a separate visit limit (24 visits/year); whereas, these same services performed by an MD or Doctor of Osteopathy (DO) will have a separate visit limit (20 visits/year).

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If you have any questions concerning the information in this announcement, please direct them to the Administrative Office at 213-386-8590 or 800-293-1370, where the staff will be happy to assist you. You may also visit the Trust's website at www.carpenterssw.org. Please remember to keep these plan change notices in the back pocket of your Summary Plan Description.

Sincerely,

THE BOARD OF TRUSTEES

Aviso a los participantes que hablan español: *Si tiene alguna pregunta tocante este aviso, o requiere alguna otra información tocante a su cobertura de salud, por favor de comunicarse con la oficina administrativa al (213) 386-8590 o (800) 293-1370, donde habrá varios representantes bilingües que le ayudarán.*

Receipt of this notice does not constitute a determination of your eligibility. If you wish to verify eligibility, or if you have any questions regarding this Plan change, please contact the Administrative Office.

In accordance with ERISA reporting requirements, this document serves as your Summary of Material Modifications to the Plan and we are advising you of these Plan changes within 60 days of the adoption of those changes.

Carpenters Southwest Administrative Corporation
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PARTICIPANT NOTICE ABOUT IMPORTANT PLAN CHANGES
April 2020

To: All Active and COBRA Participants of the Southwest Carpenters Health and Welfare Plan

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This Participant Notice will advise you of certain material modifications that will be made to the Plan. **This information is VERY IMPORTANT to you and your dependents**. Please take the time to read it carefully.

SUPPORT IN THE FIGHT AGAINST COVID-19

As information continues to unfold about the coronavirus, be assured that you can count on your Health Plan to provide the support and benefits that you and your family need.

No Deductible, Copays or Coinsurance for COVID-19 Testing

If you're showing symptoms or believe you have been exposed to the virus, we encourage you to take action. **Testing for COVID-19 will be covered at 100% as a preventive service. In-network office visits, urgent care, and emergency room visits associated with COVID-19 testing will also be covered at 100%.** You will not pay a deductible, copay, or coinsurance.

COVID-19-Related Treatment

For Kaiser members, Kaiser Permanente has announced that it will waive all member out-of-pocket costs for inpatient and outpatient services related to the **treatment** of COVID-19, for services rendered April 1, 2020 through May 31, 2020. This is intended to alleviate the cost burden and stress on impacted members of paying for care.

For participants of the Anthem PPO, the Plan will reimburse non-PPO providers (out-of-network providers) at 100% of the contracted rate that will also be paid to in-network PPO providers for treatment of COVID-19, thereby reducing and/or eliminating the member's out-of-pocket cost for services rendered April 1, 2020 through May 31, 2020.

Access to Online Medical Visits and Telehealth

Anthem Participants: During this time, online medical visits and telehealth services are available at no cost to you. To access these options online, visit **www.livehealthonline.com** to talk with a doctor or nurse any time day or night or call LiveHealth Online at (888) 548-3432. Due to an increase in calls on COVID-19, please be aware that our service partners are experiencing higher than normal wait times for their consultations over the phone and video.

Kaiser Participants: Telemedicine (telephonic visits) is offered at no cost to you year-round. Go to kp,org/getcare for information or call (800) 464-4000.

Eligibility Changes – Eligibility Extended to Maintain Health Benefits

As Trustees, we understand many of you are going through significant work disruption as a result of the coronavirus. Due to these disruptions, your health plan eligibility has been extended through the May, June, and July Eligibility Quarter. If you are currently eligible with Active benefits through April 30, 2020, you will not lose eligibility for the May, June, and July Eligibility Quarter as a result of insufficient work hours or reserve bank hours.

This is a fluid situation and as Trustees, we are monitoring this every day. We will continue to look for opportunities for the Health and Welfare Trust to support your needs.

Stay Informed to Stay Healthy

As news and advice related to COVID-19 continues to evolve, we will send updates to answer questions you may have about your health care coverage when possible. For the most up-to-date information, please visit our website at carpenterssw.org for news and announcements and other plan information. Note that your best source for the latest information about COVID-19 is the website of the Centers for Disease Control and Prevention (CDC) www.cdc.gov/coronavirus/2019-ncov/.

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ONE TIME SUPPLEMENT TO A RESERVE ACCOUNT THROUGH DECEMBER 31, 2020, FOR PARTICIPANTS WORKING UNDER A CAPPED AGREEMENT

With respect to continuation of eligibility for active carpenters, **an active carpenter's reserve account will be increased by up to 200 hours worked** under the following conditions:

a) The active carpenter is performing work for a contributing employer under a Collective Bargaining Agreement that specifies a maximum on the number of reported hours for which contributions are owed;

b) The additional hours will be credited with the first hour worked under such Collective Bargaining Agreement through December 31, 2020.

c) The additional hours will not cause the total hours in the active carpenter's reserve account to exceed the maximum number of hours worked required for eligibility for two (2) eligibility quarters.

Change to Reserve Hours Accrual for Participants Who Receive Instant Eligibility – Effective January 1, 2020

Certain Collective Bargaining Agreements provide instant eligibility for employees of a newly organized employer. Effective January 1, 2020, excess hours will be added to the reserve account of these employees beginning with the work quarter that starts six months after immediate eligibility commences. This is an improvement from the previous requirement of adding excess hours to the reserve account one year after immediate eligibility commenced.

Options for Self-Payment, Hours-Buy-Back or COBRA Premiums

The Trustees have agreed to temporarily relax the requirement to make these payments using either a money order or cashier's check. Effective with the April, May, and June eligibility months, the Trust Office will also accept a personal check.

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Sincerely,

THE BOARD OF TRUSTEES

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