LOW COST MEDICAL PLAN
SCHEDULE OF BENEFITS FOR COVERED INDIVIDUALS
All Benefits Effective January 1, 2024

COMPREHENSIVE MEDICAL BENEFITS
Coinsurance, deductibles, and out-of-pocket maximums

	PPO In-Network Provider	Out-of-Network Provider
DEDUCTIBLE (PER CALENDAR YEAR) The amount of covered medical expenses a covered individual pays each calendar year before benefits are payable by the Plan	**$600 per covered individual** **$1,800 per family**	
COINSURANCE The portion, expressed as a percentage, of covered services a covered individual will pay after the calendar year deductible is satisfied, but before the calendar year out-of-pocket max is met	**70%** **Paid by Plan**	**50%** **Paid by Plan**
	Protected Services and Continuing Care Services are payable at the PPO provider rate.	
OUT-OF-POCKET MAXIMUM (PER CALENDAR YEAR) The maximum amount that a covered individual is required to pay for covered expenses within a calendar year; after a covered individual satisfies the Plan's applicable out-of-pocket maximum, the Plan will pay 100% of most eligible covered services a covered individual incurs for the remainder of the calendar year	**$4,600 per covered individual** **$9,200 per family** *Includes calendar year deductible*	

- **After a covered individual satisfies the deductible and out-of-pocket maximum, the Plan will pay 100% of most eligible covered services for the remainder of the calendar year.**
- **Charges for Protected Services and Continuing Care Services shall accumulate to the PPO Deductible and Out-of-Pocket Maximum.**

All Schedules of Benefits highlight key features of the Active Plan of Benefits for covered individuals.

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

LOW COST MEDICAL PLAN
SCHEDULE OF BENEFITS FOR COVERED INDIVIDUALS
All Benefits Effective January 1, 2024

COMPREHENSIVE MEDICAL BENEFITS

Contracted Network Provider

BlueCross BlueShield of Illinois

For questions or information on claims or coverage, call the Fund Office at (312) 787-9455, option #3

Select services are available at the Carpenters Center for Health which are covered by the Plan at 100%
Deductibles and coinsurance do not apply

Carpenters Center for Health Powered by Premise Health. Your Family's Health Partner

4979 Indiana Ave, Suite 312, Lisle, IL • (312) 337-4150

ACA = to the extent required by the Affordable Care Act (ACA)	PPO In-Network Provider % and/or $ Amount Paid by Plan	Out-of-Network Provider % and/or $ Amount Paid by Plan
ACUPUNCTURE	See **Chiropractic, Acupuncture, & Naprapathic Care** below	
AMBULANCE SERVICE *Subject to PPO deductible*	**70%**	
ANESTHESIA or SEDATION	**70%**	**50%**
AUTISM SCREENING ACA *Calendar year deductible does not apply* • **Age Limitation:** 1 screening at age 18 months and 1 screening at age 24 months and whenever concerned • **Maximum:** 2 units per visit, 4 visits to age 2	**100%**	**Not Covered**
BEHAVIORAL HEALTH CARE	See **Behavioral Health & Substance Use Disorder and Member Assistance Program Benefits** schedule	

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LOW COST SCHEDULE OF BENEFITS FOR COVERED INDIVIDUALS: COMPREHENSIVE MEDICAL BENEFITS

All Benefits Effective January 1, 2024

ACA = to the extent required by the Affordable Care Act (ACA)	**PPO In-Network Provider** % and/or $ Amount Paid by Plan	**Out-of-Network Provider** % and/or $ Amount Paid by Plan
BREAST FEEDING SUPPORT/EQUIPMENT ACA *Calendar year deductible does not apply* • Lactation support, counseling by qualified non-physician health care professional using a face-to-face standardized curriculum (2 per pregnancy, each 30 minutes) • Non-retail purchase or rental of breast pump and related initial supplies (tubing, shields, and bottles); limited to one per pregnancy; ongoing supplies are not covered • Hospital-grade breast pump rental or purchase only if medically necessary	**100%**	**Not Covered**
CHIROPRACTIC, ACUPUNCTURE, & NAPRAPATHIC CARE (Combined Benefit) • **Max visits per Employee:** 50 per calendar year • **Max visits per Spouse:** 30 per calendar year • **Max visits per dependent children age 12 and older:** 15 per calendar year • Dependent children younger than 12, **Not Covered**	**70%**	**50%**
CLINICAL TRIALS ACA • The Plan covers routine patient costs incurred in connection with certain approved clinical trials • You must use a PPO provider if a PPO provider is participating in the approved clinical trial and will accept you as a participant in the trial. • No other charges are covered for services or items defined by the Plan as Experimental or Investigational.	**70%**	**50%**
COLORECTAL SCREENINGS ACA The following are only covered for individuals **age 45 and older**: • **Once per calendar year:** fecal occult blood test • **Once every 3 years:** Cologuard® at-home screening • **Once every 5 years with preventive diagnosis:** facility fees; anesthesia; surgical consultation, procedure, and pathology	**100%**	**Not Covered**
CONTRACEPTIVES ACA *Calendar year deductible does not apply* Includes related office visits. **FDA-approved methods for females with reproductive capacity:** contraceptive support & counseling; diaphragms, sponges, cervical caps, female condoms & spermicides; vaginal rings; emergency contraceptives (generic morning-after pill only); implants & implantable rods; oral contraceptives (generic only); patch; injectables; IUD	**100%**	**Not Covered**
COSMETIC SURGERY Solely to improve appearance	**Not Covered**	
DENTAL CARE/SERVICES For non-occupational injury to teeth	**Not Covered**	
DIAGNOSTIC IMAGING MRI, CAT/CT Scans, PET Scans	**70%**	**50%**
DIAGNOSTIC X-RAYS AND LAB TESTS	**70%**	**50%**
DURABLE MEDICAL EQUIPMENT	**70%**	**50%**
EMERGENCY SERVICES Facility and Physician Fees	**70%** **Copayment: $300 per Emergency Room visit** Waived if admitted to the Hospital as in-patient within 72 hours or held in observation unit for more than 24 hours; no longer applicable after covered individual meets the applicable calendar year out-of-pocket maximum	
EXTENDED CARE/SKILLED NURSING FACILITY Maximum of **120 days** per convalescent period	**70%**	**50%**
GENDER AFFIRMING CARE	**70%**	**50%**
GENETIC TESTING ACA	**100%** *Calendar year deductible does not apply*	**50%** *Subject to calendar yr deductible, out-of-pocket max, &* **$7,500 combined annual max benefit**
GENETIC TESTING, DIAGNOSTIC Subject to calendar year deductible and **$7,500 combined annual max benefit** Non-Diagnostic Genetic Testing **Not Covered**	**70%**	**50%**
HEARING BENEFITS	**Not Covered** EXCEPT as required by the Affordable Care Act under the Wellness and Preventive Care Benefit	
HOME HEALTH CARE Maximum of **120 visits** per year	**70%**	**50%**
HOSPICE CARE Lifetime maximum of **180 days** per covered individual	**70%**	**50%**

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LOW COST SCHEDULE OF BENEFITS FOR COVERED INDIVIDUALS: COMPREHENSIVE MEDICAL BENEFITS

All Benefits Effective January 1, 2024

ACA = to the extent required by the Affordable Care Act (ACA)		PPO In-Network Provider % and/or $ Amount Paid by Plan	Out-of-Network Provider % and/or $ Amount Paid by Plan
HOSPITAL CARE Confinement maximum of **180 days** per calendar year for in-patient care, unless deemed Medically Necessary to continue Hospital care beyond 180 days		**70%**	**50%**
INFERTILITY SERVICES Includes hospital, physician, prescription drugs, and treatments; excludes diagnostic genetic testing (see above). **$60,000 combined lifetime maximum** for services provided to Employee and spouse; dependent children **Not Covered**.		**70%**	**50%**
INFUSION THERAPY For the administration of an intravenous prescription drug		**70%**	**50%**
MEMBER ASSISTANCE PROGRAM		See **Behavioral Health & Substance Use Disorder and Member Assistance Program Benefits** schedule	
NAPRAPATHIC CARE		See **Chiropractic, Acupuncture, & Naprapathic Care** above	
NUTRITIONAL COUNSELING/ THERAPY	• Covered individuals participating in the bariatric program maintained by the contracted provider • For treatment of: eating and gastrointestinal disorders; cardiovascular, kidney, and chronic obstructive pulmonary diseases; diabetes; hypertension; seizures; and cancer	**70%**	**50%**
	ACA For the following diagnoses in covered individuals age 19 or older: obesity, diabetes, cardiovascular and kidney diseases	**100%** *Calendar year deductible does not apply* Limited to **4 sessions per year**	
ORAL AND MAXILLOFACIAL SURGERY		**70%**	**50%**
ORGAN TRANSPLANT		**70%**	**50%**
PHYSICIAN SERVICES		**70%**	**50%**
PREGNANCY CARE Note 1: 70%, except to the extent required under the ACA Note 2: 100%, for services covered under ACA, *calendar year deductible does not apply*		**70%** ◄See Note 1 / **100%** ◄See Note 2	**50%**
PROSTHETICS	**Artificial limbs and eyes**	**70%**	**50%**
	Wigs, hairpieces: for hair loss resulting from cancer diagnosis or an organ transplant treatment	**Not Covered**	
RECONSTRUCTIVE BREAST SURGERY		**70%**	**50%**
STERILIZATION	**Females** ACA Coverage applies to all places of service, except Emergency Rooms; separately billed services not covered under preventive services, subject to the normal benefits based on place of service	**100%** *Calendar year deductible does not apply*	**Not Covered**
	Males	**70%**	**Not Covered**
	Sterilization Reversals Female and Male	**Not Covered**	
SUBSTANCE USE DISORDER		See **Behavioral Health & Substance Use Disorder and Member Assistance Program Benefits** schedule	
SURGI-CENTER FACILITY	**Hospital-affiliated**	**70%**	**50%**
	No Hospital affiliation	**70%**	**Not Covered**
SURGICAL ASSISTANT or ASSISTANT SURGEON		**70%**	**50%** Limited to 20% of surgical procedure Reasonable & Customary allowance
SURGICAL CONSULTATIONS		**70%**	**50%**
TEMPORO-MANDIBULAR JOINT CARE (TMJ)	**Physician & therapy services**	**70%**	**50%**
	Appliances and their adjustments for TMJ and bruxism (occlusal)	**70%** Once every three (3) consecutive years **Lifetime Max of two (2) appliances**	

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LOW COST SCHEDULE OF BENEFITS FOR COVERED INDIVIDUALS: COMPREHENSIVE MEDICAL BENEFITS All Benefits Effective January 1, 2024			
ACA = to the extent required by the Affordable Care Act (ACA)		**PPO In-Network Provider** % and/or $ Amount Paid by Plan	**Out-of-Network Provider** % and/or $ Amount Paid by Plan
THERAPY SERVICES	**Physical and Speech Outpatient Therapy** Max **50 visits** per calendar year*	**70%**	**50%**
	Occupational Outpatient Therapy Max **50 visits** per calendar year*	**70%**	**50%**
	***Amount covered after 50 visit max is reached with additional benefit approved** Only for conditions listed to the right **and** only if medical records substantiate that improvement is being made & additional therapy will continue improvement.	**50%**	**30%**
		Cerebral palsy, cerebral vascular incident (stroke), intracranial bleed/other head traumas, spinal cord injuries, multiple/complicated fractures, or other catastrophic diagnoses with neurological implications, significant or multiple injuries and/or illnesses	
	Physical, Occupational, and Speech Outpatient Therapy for Developmental Disabilities Habilitative or to teach; for covered individuals thru age 18	**70%**	**50%**
URGENT/IMMEDIATE CARE FACILITIES and RETAIL CLINICS		**70%**	**50%**
VISION SURGERY Excluding cosmetic or refractive corrections		**70%**	**50%**
WELLNESS and PREVENTIVE CARE[ACA] includes routine screenings, immunizations, and other services (see www.healthcare.gov)		**100%** *Calendar year deductible does not apply*	**Not Covered**

BEHAVIORAL HEALTH & SUBSTANCE USE DISORDER BENEFITS

Plan's Preferred Contracted Network Provider:

BlueCross BlueShield of Illinois

BlueCross BlueShield of Illinois (BCBSIL)*
For questions or information on claims or coverage, call the Fund Office at (312) 787-9455, option #3

	BCBSIL In-Network Provider % and/or $ Amount Paid by Plan	**BCBSIL Out-of-Network Provider** % and/or $ Amount Paid by Plan
EMERGENCY SERVICES Facility and Physician Fees	**70%**	
	Copayment: $300 per Emergency Room visit Waived if admitted to the Hospital as in-patient within 72 hours or held in observation unit for more than 24 hours; no longer applicable after Covered individual meets Calendar Year Out-of-pocket max	
HOSPITAL CARE and RESIDENTIAL TREATMENT FACILITIES Confinement maximum of **180 days** per calendar year combined for Hospital & Residential Treatment in-patient care, unless deemed Medically Necessary to continue Hospital care beyond 180 days	**70%**	**50%**
HOSPITAL OUTPATIENT DIAGNOSTIC TESTS	**70%**	**50%**
OUTPATIENT THERAPY Including partial hospitalization	**70%**	**50%**
CUSTODIAL OR GROUP HOMES	**Not Covered**	

MEMBER ASSISTANCE PROGRAM

Plan's Preferred Contracted Network Provider:

lyra

Lyra Health
(877) 368-0644Available 24/7
www.carpenterbenefits.lyrahealth.com

	Lyra In-Network Provider % and/or $ Amount Paid by Plan	**Lyra Out-of-Network Provider** % and/or $ Amount Paid by Plan
MEMBER ASSISTANCE PROGRAM *Calendar year deductible does not apply* **12 sessions** per calendar year	**100%**	**Not Covered**

** Lyra Health providers may also qualify as Network Providers under the BCBSIL behavior health network.*

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LOW COST MEDICAL PLAN
SCHEDULE OF BENEFITS FOR COVERED INDIVIDUALS

All Benefits Effective January 1, 2024

PRESCRIPTION BENEFITS

For Apprentices, availability is subject to initial and continuing eligibility rules.

Claims must be submitted to the Plan's Contracted Network Providers

Express Scripts
(800) 939-2089
Representatives available 24/7
www.express-scripts.com

Accredo
(800) 803-2523
M – F: 7 a.m. to 10 p.m.
SAT: 7 a.m. to 4 p.m.
www.accredo.com

	EXPRESS SCRIPTS		ACCREDO
	Retail Pharmacy Network Lesser of 100 units or 30-day supply	**Mail Order Program or Walgreens** Up to a 90-day supply	**Specialty Medications** For complex conditions (cancer, hemophilia, etc.)
OUT-OF-POCKET MAXIMUM *Per calendar year*	**$2,000 per covered individual** **$4,000 per family**		
GENERIC Co-payment per drug	**70% paid by Plan**		
SINGLE-SOURCE BRANDS *Generic not available* Copayment per drug	**70% paid by Plan**		
GENERIC/ MULTI-SOURCE BRANDS *Generic available* Copayment per drug	**70% paid by Plan**		
OMNIPOD INSULIN PUMP	**70% paid by Plan**		
NON-SELECT SPECIALTY MEDICATIONS Copayment per drug Used to treat complex conditions such as cancer, hemophilia, immune deficiency, rheumatoid arthritis, etc. and require a higher level of care			**70% paid by Plan**
SELECT SPECIALTY MEDICATIONS *Must enroll in the SaveOn SP Program through Accredo for this benefit. For a list of covered specialty medications, please visit www.Accredo.com*			**$0 Copayment per Drug** for members enrolled in the *SaveOn SP Program*

LIFE INSURANCE

Self-funded

	Eligible Participant	Spouse	Child
POLICY AMOUNT	**$5,000**	**$1,000**	**$1,000**

EXCLUDED BENEFITS

Vision Benefits	**Dental Benefits**	**Short-Term Disability Benefits**	**Accidental Death & Dismemberment (AD&D) Insurance Benefits**