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FOR GROUPS 51242-00, -02, -04, -06, and -08

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Standard Plan C

(Groups 63242-01, -03, -05, and -07)

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BENEFITS PROVIDED BY SECURITY BLUE

(a Highmark Blue Cross/Blue Shield Medicare HMO currently available in the following Counties: Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Crawford, Erie, Fayette, Greene, Indiana, Lawrence, Mercer, Somerset, Washington and Westmoreland)

(Groups 584031, 884039 and 884040)

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SCHEDULE OF BENEFITS

FOR ACTIVE EMPLOYEES AND EARLY RETIREES

EMPLOYEE DEATH BENEFITS

New Employees covered less than two Benefit Periods .... $ 2,500

Regular Employees
covered for two or more Benefit Periods .... $ 5,000

Regular Employees
covered for ten or more Benefit Periods.......... $10,000

Death Benefits for Early Retirees will be reduced by the amount of any Death Benefit payable under the Carpenters’

Pension Fund of Western Pennsylvania

EMPLOYEE ACCIDENTAL DEATH
AND DISMEMBERMENT BENEFITS

New Employees covered less than two Benefit Periods .... $ 2,500

Regular Employees
covered for two or more Benefit Periods .... $ 5,000

Regular Employees
covered for ten or more Benefit Periods......................... $10,000

Employees who have been ineligible for two or more consecutive Benefit Periods shall be considered New Employees for the purpose
of determining the amount of Death or Accidental Death Benefits

EMPLOYEE WEEKLY DISABILITY BENEFITS

For Active Employees Only .... $ 200

Benefits begin an the eighth day of disability
for a maximum period of fifteen weeks

DEPENDENT DEATH BENEFIT

Spouse (Husband or Wife) .... $ 1,500

Dependent Child or Children over six months old .... $ 750

BENEFITS FOR ACTIVE EMPLOYEES AND
EARLY RETIREES AND THEIR ELIGIBLE DEPENDENTS

HOSPITALIZATION

Blue Cross 365 Day Plan .... Semi-Private Care

PHYSICIAN SERVICES

Blue Shield Plan .... Prevailing Fee Contract

SUPPLEMENTARY MEDICAL BENEFITS COVERING:

Outpatient Treatment for a Mental or Nervous Disorder
Home and Office Medical Visits
Blood or Blood Plasma
Ambulance Service
Prescription Drug Expenses
Private Duty Nursing Service
Oxygen and the Rental of Equipment for its Administration
Oral Surgery
Miscellaneous Supplemental Medical Benefits
Outpatient Chemotherapy Provided in a Home Setting
Durable Medical Equipment
Hairpieces/Wigs
Hearing Aids

See pages 38 through 45 for specific conditions and limitations

VISION CARE BENEFITS ....As Scheduled (Page 44)

SCHEDULE OF BENEFITS

FOR PERMANENTLY DISABLED RETIREES UNDER AGE 65 AND THEIR ELIGIBLE DEPENDENTS

Disabled Retirees eligible for Medicare Parts A and B must be enrolled in Medicare in order to be eligible for benefits under the Plan. With respect to individuals enrolled in Medicare, these benefits are secondary to the benefits payable by Medicare and will supplement Medicare to assure the continued level of payment of the pre-Medicare amount.

If a dependent of a Disabled Retiree is entitled to Medicare Parts A and B, the dependent must be enrolled in Medicare in order to be eligible for benefits under this Plan. The Plan Office must be notified that the dependent is entitled to and enrolled in Medicare. Benefits for these dependents are secondary to the benefits payable by Medicare, as noted above, and will supplement Medicare to assure the continued level of payment of the pre-Medicare amount.

FOR DISABLED RETIREES AND ELIGIBLE DEPENDENTS ELIGIBLE FOR MEDICARE

HOSPITALIZATION .... Blue Cross Medigap Plan C

PHYSICIAN SERVICES .... Blue Shield Medigap Plan C

-or-

CARPENTER'S SECURITY BLUE MEDICARE HMO
(in certain counties)

FOR DISABLED RETIREES AND ELIGIBLE DEPENDENTS NOT ELIGIBLE FOR MEDICARE

HOSPITALIZATION

Blue Cross 365 Day Plan .... Semi-Private Care

PHYSICIAN SERVICES

Blue Shield Plan .... Prevailing Fee Contract

SUPPLEMENTARY MEDICAL BENEFITS COVERING:

- Outpatient Treatment for a Mental or Nervous Disorder
- Blood or Blood Plasma
- Ambulance Service
- Private Duty Nursing Service
- Oxygen and the Rental of Equipment for its Administration
- Oral Surgery
- Outpatient Chemotherapy Provided in a Home Setting
- Durable Medical Equipment

NOTE: This group of participants does not have Supplementary Benefits covering Home and Office Visits, Prescription Drug Expenses, Vision Care Benefits, Miscellaneous Supplemental Medical Benefits, Hairpieces/Wigs, or Hearing Aids

See pages 38 through 45 for specific conditions and limitations

SCHEDULE OF BENEFITS

FOR SENIOR RETIREES AND ELIGIBLE DEPENDENTS
AGE 65 AND OVER

HOSPITALIZATION ....Blue Cross Medigap Plan C
PHYSICIAN SERVICES.................................Blue Shield Medigap Plan C
-or-
CARPENTER'S SECURITY BLUE MEDICARE HMO
(in certain counties)

FOR SENIOR RETIREES' ELIGIBLE DEPENDENTS
UNDER AGE 65
(It not entitled to Medicare)

HOSPITALIZATION
Blue Cross 365 Day Plan ....Semi-Private Care

PHYSICIAN SERVICES
Blue Shield Plan .... Prevailing Fee Contract

SUPPLEMENTARY MEDICAL BENEFITS COVERING:
- Outpatient Treatment for a Mental or Nervous Disorder
- Blood or Blood Plasma
- Ambulance Service
- Private Duty Nursing Service
- Oxygen and the Rental of Equipment for its Administration
- Oral Surgery
- Outpatient Chemotherapy Provided in a Home Setting
- Durable Medical Equipment

NOTE: This group of participants does not have Supplementary Benefits covering Home and Office Visits, Prescription Drug Expenses, Vision Care Benefits, Miscellaneous Supplemental Medical Benefits, Hairpieces/Wigs, or Hearing Aids.

See pages 38 through 45 for specific conditions and limitations

ELIGIBILITY RULES

This portion of the Medical Plan Summary describes in general terms the rules which determine whether or not you are eligible to receive benefits under the Plan. By finding your particular classification on the list of Classification of Participants on page 22, and carefully reading the regulations for that classification, you will know if you are eligible for benefits. If you are not eligible, the rules will explain what is necessary for you to become eligible. Note that your classification will be determined as of March 1 and September 1 of each year.

These rules are very important, and you should read them thoroughly. The following definitions of important terms used in this section will help you to understand the rules.

DEFINITIONS OF IMPORTANT TERMS

ACTIVE EMPLOYEE — You are an Active Employee if you are actively employed or available for employment in the industry, and have not retired. If you are temporarily disabled but otherwise available for employment, you are still considered an Active Employee, provided you meet the eligibility requirements of the Plan.

RETIRED EMPLOYEE — You are a Retired Employee (Retiree) if you have withdrawn from active employment in the industry and are receiving retirement benefits under the Carpenters' Pension Fund of Western Pennsylvania, Social Security, or a similar retirement plan.

There are different programs of benefits under this Plan, which are listed in the Schedules of Benefits on pages 1 through 5. Early Retirees, those retirees who are under age 65, will have the same program of benefits as Active Employees. Separate programs of benefits are available to Senior Retirees, those retirees who are age 65 or over and eligible for Medicare, and to Permanently Disabled Retirees. Even though you are a Retired Employee, you will maintain your Active Employee medical coverage until your active eligibility expires.

PARTICIPANT — If you are employed by a Contributing Employer or Participating Union which makes contributions on your behalf to the Carpenters' of Western Pennsylvania Medical Plan, you are considered a participant. Active participants are those participants who are actively employed or available for employment with a Contributing Employer. Retired participants are participants who have retired and qualify for retirement benefits.

CONTRIBUTING EMPLOYER — A Contributing Employer is an Employer who makes contributions to the Carpenters' of Western Pennsylvania Medical Plan on your behalf according to a signed Collective Bargaining Agreement or a Participation Agreement.

EMPLOYER CONTRIBUTIONS — An Employer Contribution is a payment received from a Contributing Employer and includes Employer Contributions transferred under Reciprocal Agreements with other Welfare Funds.

VOLUNTARY CONTRIBUTIONS — Voluntary Contributions are optional self-payments made by a participant in the Carpenters' of Western Pennsylvania Medical Plan for the purpose of maintaining eligibility under the Plan. Contributions must be made as instructed on the semi-annual eligibility statement.

WORK PERIOD — The Work Period is a six-month time frame during which you earn Employer Contributions for eligibility. There are two (2) Work Periods each year:

JANUARY 1st through JUNE 30th; and
JULY 1st through DECEMBER 31st.

BENEFIT PERIOD — The Benefit Period is the six-month time frame during which your Employer or Voluntary Contributions earn medical benefits for you and your eligible dependents. The two (2) Benefit Periods are:

OCTOBER 1st through MARCH 31st; and
APRIL 1st through SEPTEMBER 30th.

LAG PERIOD — The Lag Period is the three-month time frame between a Work Period and a Benefit Period. During the Lag Period you may be permitted to make Voluntary Contributions if you have not earned enough in Employer Contributions to maintain your eligibility for the next Benefit Period. The two Lag Periods are:

JULY 1st through SEPTEMBER 30th; and
JANUARY 1st through MARCH 31st.

INITIAL ELIGIBILITY

As a participant in the Carpenters' of Western Pennsylvania Medical Plan, you and your eligible dependents will be covered for hospital, medical, disability and death benefits. Your benefits will normally begin on the first (1st) day of the Benefit Period which follows a period of six (6) months of employment (the Work Period) in which you have either earned sufficient Employer Contributions to be eligible for coverage, or have been credited with a combination of Employer Contributions and Voluntary Contributions which are sufficient to obtain coverage.

The amount of Employer Contributions and/or Voluntary Contributions which are required to earn initial eligibility depend on your employee classification. The contribution requirements for each classification are listed on page 24. Although Voluntary Contributions may be made in order to meet the contribution requirements for eligibility, a minimum of $350 in Employer Contributions must be earned during the Work Period before you will be permitted to make Voluntary Contributions to complete the requirements. Under certain circumstances, such as for an apprentice or a new employee entering the industry, this rule is modified. Please refer to the next section for additional information on eligibility in these situations. Also, contact the Plan Office for additional information.

For example, if you have earned the required amount of Employer Contributions during the Work Period between January 1 and June 30, you will be eligible for benefits during the Benefit Period from October 1 through March 31. If you haven't earned the required amount, but have earned at least $350 in Employer Contributions during that Work Period, you may make Voluntary Contributions during the Lag Period from July 1 through September 30 to reach the total amount required for coverage.

If you earn the required amount of Employer Contributions during the Work Period from July 1 through December 31, you will be eligible for benefits during the Benefit Period from April 1 through September 30. If you don't earn the required amount, but did earn at least $350 in Employer Contributions, you can still be eligible if you make Voluntary Contributions between January 1 and March 31 to make up the difference.

SCHEDULE OF WORK/BENEFIT PERIODS

WORK PERIODS	LAG PERIODS	BENEFIT PERIODS
Jan. 1 to June 30	July 1 to Sept. 30	Oct. 1 to March 31
July 1 to Dec. 31	Jan. 1 to March 31	April 1 to Sept. 30

SPECIAL ELIGIBILITY RULES

ELIGIBILITY RULE FOR NEW EMPLOYEES — New employees (i.e., members working at the trade who were never previously covered under the Medical Plan) will be permitted to make a Voluntary Contribution to make themselves eligible on the first (1st) day of the Benefit Period immediately following (1) the date they first became employed by a Contributing Employer; or (2) in the case of an employee of a new employer, the first (1st) day of the Benefit Period immediately following the date such new employer became obligated to contribute to the Medical Plan. In other words, new employees who do not wish to delay their eligibility until the Benefit Period following the Work Period in which they earn the required contributions, may elect to be covered the first (1st) day of the Benefit Period immediately following the date they become a participant. They can initiate their coverage by making a Voluntary Contribution. They will not be required to have the minimum amount of $350 in Employer Contributions normally required for Initial Eligibility. The privilege of making a Voluntary Contribution for Initial Eligibility is limited to the new employees only once, and this privilege must be exercised prior to the beginning of a Benefit Period immediately following the date they become initially employed.

Individuals in the apprenticeship program are considered to be employees of new employers for purposes of this provision. Further, this provision is extended to new employees who have not previously worked within the jurisdiction of the Plan upon gaining initial employment with any Contributing Employer. This does not apply to new employees who are covered by a Reciprocity Agreement as a result of their participation in other plans.

EFFECTIVE DATE OF COVERAGE

Normally, you and your dependents will be covered for all benefits on the first (1st) day of a Benefit Period (either April 1 or October 1) following the Work Period in which you have satisfied the minimum eligibility requirements. However, if prior to the first (1st) day of that Benefit Period you are hospitalized, medical and disability benefits will not be paid for any expenses directly or indirectly related to that illness or injury until the earlier of the date you return to work or are available to return to work as certified by your attending physician, or the date you are discharged from the hospital.

Similarly, if you have dependents who are hospitalized prior to your initial date of eligibility, their coverage for that hospital admission will not become effective until the date they recover and are able to resume their normal activities, as certified by their attending physician, or the date they are discharged from the hospital.

Finally, it should be noted that no death benefit of any kind will be paid if an eligible employee or dependent dies within the first 120 days following their initial date of eligibility as a direct or indirect result of an injury or illness which was incurred or sustained prior to the initial date of eligibility.

CONTINUING ELIGIBILITY

Your eligibility for benefits continues for the six (6) months of each Benefit Period which follows a Work Period in which the Plan has received sufficient Employer Contributions to maintain your eligibility, or you have been credited with sufficient Employer Contributions and/or Voluntary Contributions to continue coverage, as set forth in the Schedule of Required Contributions on page 24) provided you continue to be available for work in Covered Employment. If you are working for an employer who is not covered by a Collective Bargaining Agreement which requires that contributions be made to the Plan on your behalf, and that employer is performing the same type of work for which contributions are normally made to the Plan, then your eligibility for benefits will be terminated at the end of the month during which you began working for the non-contributing employer.

ELIGIBILITY FOR DEPENDENTS

Generally, your dependents become eligible for benefits at the same time you do. There are exceptions if your dependent is disabled prior to your Effective Date, as noted above in the section on the Effective Date of Coverage.

Your eligible dependents include the following persons who are not employed by a Contributing Employer:

1. Your legal spouse. Note that in the case of a common law marriage, the Plan rules require that eligibility for dependents acquired through common law marriage is not effective until the date that proof of such marriage is accepted by the Plan Office. Eligibility for coverage will not be made retroactive beyond the date proper notification of common law marriage is received.

2. Each unmarried child under 19 years of age, including the natural and adopted children of the employee and may include stepchildren residing in the

household of the employee if the employee has assumed the financial responsibility for the child and another parent is not legally responsible for support for and medical expenses of the child. If a natural parent is to pay $300 or more a month for child support, this will be considered legally responsible for support for and medical expenses of the child and this stepchild will not be eligible for coverage under the Plan. Adopted children also include those living with the adopting parent during the probationary period.

3. Each unmarried child as defined above, age 19 or over, but under 23 years of age, who is enrolled as a full-time student in a college (defined as 12+ credits), university, trade or training school, or is completing high school as a full-time student. It is your responsibility to contact the Fund Office prior to the dependent’s 19th birthday to obtain the necessary information in order to document eligibility.

4. Each unmarried child as defined above, age 19 or over, who is unable to perform any work for gainful employment and depends on you for principal support because of a mental or physical handicap. The mental or physical handicap must be certified by a physician and must have occurred prior to the dependent’s 19th birthday and while the dependent was covered for benefits under this Plan.

Please contact the Plan Office for an application prior to the dependent’s 19th birthday. Coverage for such dependent will be continued for as long as you remain covered under the Medical Plan and for as long as the dependent remains in such condition.

For Senior Retirees, eligible dependents are the eligible Senior Retiree’s spouse and only those natural or legally adopted children (as defined above) who were enrolled in the Plan at the time of the participant’s retirement. No new spouses or new dependents can be added after the retirement date.

For Disabled and Early Retirees, only the spouse at the time of retirement is covered. A new spouse cannot be added. However, additional natural children from the current marriage may be added after the retirement date.

ELIGIBILITY FOR ACTIVE PARTICIPANTS

For Active Members only, should the individual not have sufficient Employer Contributions from the current six (6) month Work Period, the Plan will “look back” to the prior six (6) month Work Period to see if the employee had any excess Employer contributions as compared to the current eligibility requirement.

As an example, let us look at the Benefit Period which starts October 1, 1999 and ends March 31, 2000. In order to be eligible for this Benefit Period, an Active Member needs the following in Employer Contributions:

$1,570 for work performed during the Work Period
January 1, 1999 through June 30, 1999

or

$3,140 for work performed during the Work Period
July 1, 1998 through June 30, 1999

Note that this look-back provision applies only to members who are currently active. The provision does not apply to Retirees.

ELIGIBILITY FOR TEMPORARILY DISABLED PARTICIPANTS

(Applicable Only To Employees Who Are Not Retired)

If you become disabled during a Benefit Period in which you are eligible, the Plan will “credit” your account with a certain amount of contributions for each week of disability, beginning with your second (2nd) week of disability. The amount of the credit per week will be one-thirteenth (1/13) of the current

six (6) month eligibility requirement. Credits will be issued only for the period of time during the Work Period that you were disabled. No more than one (1) year of medical coverage can be obtained under this provision for any one (1) continuous period of disability.

If the total amount of Employer Contributions earned and the Disability Credits provided by the Fund are insufficient to establish your eligibility for the next Benefit Period, you may continue your eligibility by making a Voluntary Contribution.

To receive these Disability Credits, you must be under the care of a licensed physician and unable to perform your normal occupation. You are required to notify the Administrative Office that you are disabled, and furnish the Office with satisfactory proof of your disability. Evidence that you are receiving Workers' Compensation Benefits will be considered satisfactory proof of disability. However, if you are not receiving Workers' Compensation Benefits, you will be required to submit a statement from your doctor that you are unable to perform your normal occupation.

ELIGIBILITY FOR PERMANENTLY DISABLED PARTICIPANTS

If you become totally and permanently disabled while eligible for benefits and before attaining age 65, and you qualify for and are awarded a Disability Retirement Benefit under the Carpenters' Pension Fund of Western Pennsylvania, you may continue your eligibility through Voluntary Payments as long as you remain totally disabled.

You will be offered a choice between Retiree Only and Family Coverage. As a Disabled Retiree, you must maintain continuous coverage in order to remain eligible to participate in the Plan. If for two (2) consecutive Benefit Periods you have not made Voluntary Contributions to continue your coverage, your eligibility and/or that of your dependents will terminate, and you will not be permitted to become a participant again at a later date. In other words, if you elect not to participate, you will not be able to participate at a later date. If you elect Retiree Only coverage, you will not be permitted to add your family at a later date.

Should a disabled participant under age 65 recover during a Benefit Period, his coverage will be continued to the last day of the Benefit Period during which recovery occurred. Thereafter, he will be subject to the eligibility requirements for Active Participants. A participant who recovers sufficiently to be gainfully employed shall no longer be considered a Disabled Employee.

Note that Permanently Disabled Participants not qualifying for coverage under the Permanently Disabled Participant category (e.g., not eligible for Medical Coverage in the period the disability began) may qualify for coverage under the Early Retiree category. Please refer to that section for more information.

Also note that Disabled Participants eligible for Medicare may have a choice between two plans of coverage – Medicare Supplemental Standard Plan C and the Carpenters' Security Blue Program. Please refer to those sections for more information.

ELIGIBILITY FOR EARLY RETIRED PARTICIPANTS

When you retire, if you are at least age 55 but have not yet attained age 65, and are receiving Early Retirement Benefits from either the Carpenters' Pension Fund of Western Pennsylvania or the Social Security Administration, you may continue your eligibility through Voluntary Payments if ALL of the following requirements are met:

1. You have been an Active Participant under the Medical Plan for a period of ten (10) years. Service Credit for work in the industry as recorded by the Carpenters' Pension Fund of Western Pennsylvania will be considered as satisfactory evidence of years of participation. Reciprocal credits honored

under the Carpenters' Pension Fund of Western Pennsylvania will also be accepted.

2. You were eligible as an Active Participant in the Medical Plan in at least six (6) out of the last ten (10) Benefit Periods prior to retirement.

3. You submit to the Administrative Office a properly completed application to participate in the Medical Plan as an Early Retiree, and the application is approved by the Board of Trustees.

4. Upon approval of your application by the Board of Trustees, you make the required Voluntary Contributions in accordance with the regulations pertaining to such contributions.

As an Early Retiree, you must maintain continuous coverage in order to remain eligible to participate in the Plan. If for two (2) consecutive Benefit Periods you have not made Voluntary Contributions to continue your coverage, your eligibility will terminate, and you will not be permitted to become a participant again at a later date, unless you do so solely through Employer Contributions. If you again become eligible through Employer Contributions, you will not be permitted to make Voluntary Contributions for future benefit periods unless you earn reinstatement through 1,000 hours of employment.

Note that Permanently Disabled Participants not qualifying for coverage under the Permanently Disabled Participant category (e.g., not eligible for Medical Coverage in the period the disability began) may qualify for coverage under the Early Retiree Category if they meet all requirements of Early Retiree participation, with the exception of the age requirement.

ELIGIBILITY FOR SENIOR RETIREES

Retired Employees age 65 and over who are eligible and enrolled for Medicare Parts A and B are classified as Senior Retirees and are covered under a separate program of benefits, described in the Schedule of Benefits for Senior Retirees.

To be eligible to participate as a Senior Retiree, the individual must have been an eligible participant in the Medical Plan for at least six (6) out of the last ten (10) Benefit Periods.

You will be offered a choice between Retiree Only and Family Coverage. As a Senior Retiree, you must maintain continuous coverage in order to remain eligible to participate in the Plan. If for two (2) consecutive Benefit Periods you have not made Voluntary Contributions to continue your coverage, your eligibility will terminate, and you will not be permitted to become a participant again at a later date, unless you do so solely through Employer Contributions. If you again become eligible through Employer Contributions, you will not be permitted to make voluntary contributions for future benefit periods unless you earn reinstatement through 1,000 hours of employment. In other words, if you elect not to participate, you will not be able to participate at a later date without returning to work. If you elect Retiree Only coverage, you will not be permitted to add your family at a later date.

Note that senior retirees eligible for Medicare may have a choice between two plans of coverage — Medicare Supplemental Standard Plan C and the Carpenters' Security Blue Program. Please refer to those sections for more information.

RECIPROCAL AGREEMENTS

In order to extend protection to those employees who from time to time must work outside the jurisdiction of this Fund, Reciprocal Agreements have been executed with many of the Welfare Funds in adjacent areas. These Reciprocal Agreements provide for the transfer to this Fund of contributions earned by employees who are temporarily working under the jurisdiction of other such Welfare Funds.

Before leaving the jurisdictional area of the Plan, you should check with

the Administrative Office to make certain that this Plan has a Reciprocal Agreement in effect with the Welfare Fund in the area where you will be working. You must also complete and return to this office a “Request for Transfer of Contributions” form. These forms can be obtained from the Administrative Office.

If there is no Reciprocal Agreement in effect, you may be able to continue your coverage by making a Voluntary Contribution.

TERMINATION OF COVERAGE

You and/or your dependents can lose eligibility for coverage under any one (1) of the following circumstances:

1. Failure to Accumulate the Required Contributions—

You will lose eligibility for coverage for yourself and your dependents on the last day of the Benefit Period which precedes a Benefit Period for which you did not meet the continuing eligibility requirements as described on page 10.

2. Working For a Non-Contributing Employer—

Your benefits and those of your dependents will be terminated if you take work for an employer who is not covered by a Collective Bargaining Agreement which requires that contributions be made to the Fund on your behalf and who is performing the same type of work for which contributions are normally made to the Plan. Your eligibility for Fund benefits will be terminated at the end of the month during which you began working for that non-contributing employer.

3. Entrance Into The Armed Forces—

Your benefits and those of your dependents will immediately cease upon entrance into active duty in the U.S. Armed Forces. If you return to active employment at the trade upon discharge from active duty, you may apply for reinstatement of benefits for yourself and your dependents. Contact the Administrative Office for proper procedures.

4. Termination of Dependent Coverage

A dependent’s eligibility for coverage will automatically terminate when he or she ceases to qualify as a dependent under the “Eligibility for Dependents” rules which were outlined in an earlier section.

VOLUNTARY CONTRIBUTIONS

Participants who might otherwise lose their benefits because of insufficient Employer Contributions have the option of making Voluntary Contributions in order to remain eligible for benefits under the Plan. Apprentices may make an unlimited number of Voluntary Contributions. Journeymen may continue eligibility through Voluntary Contributions for a maximum of four (4) consecutive Benefit Periods.

You will receive semi-annual eligibility statements from the Administrative Office, which will include instructions for making Voluntary Contributions if necessary. All Voluntary Contributions must be made within the three (3) month Lag Period following the end of a Work Period and as instructed by the Administrative Office.

You may continue eligibility through Voluntary Contributions for a maximum of four (4) consecutive Benefit Periods, and then your coverage will be terminated. No further statements will be issued after the four (4) Benefit Periods. In order to be reinstated for benefits under the Plan after you have been terminated, you must complete the requirements for initial eligibility described at the beginning of this section. Your self-payment number will not revert to zero until you earn eligibility solely through Employer Contributions.

If you do not return to work for a Contributing Employer after four (4) consecutive Benefit Periods, you may be allowed to continue Voluntary Contributions if you can provide satisfactory proof of continued employment

within the Trade, or if you can provide satisfactory proof of availability for employment within the geographic area covered by the Plan. Union membership does not constitute proof of continued availability.

Concerning active employees, withdrawn or terminated members are not available for work in covered employment within the jurisdiction and are thus not eligible to make self-payment.

You may also be allowed to continue Voluntary Contributions if you can provide satisfactory proof of your continued temporary disability. Since statements will not automatically be sent, it will be your responsibility to notify the Plan Office prior to the start of each Benefit Period that you fall into this category.

The amount of Voluntary Contribution which a Retiree is required to pay for continued coverage may vary if the person who retired was younger than 65 at the time he retired, but will attain age 65 and become eligible for the Senior Retiree Program during the Benefit Period for which the payment is being made. In such instances, the payments listed on page 24 will be pro-rated between the months during the Benefit Period in which he is younger than 65 and those months in which he is age 65 and over, and the level of benefits will be determined accordingly.

Spouses and dependent children of an employee who dies while eligible for coverage under the Plan may continue their coverage for the duration of the Benefit Period in which the eligible participant died and for the two (2) Benefit Periods immediately following. If sufficient Employer Contributions were not earned during the Work Period in which the employee died, the surviving dependents must make a Voluntary Contribution to make up the shortage. The amount of the Voluntary Contribution which the surviving dependents must make will be determined according to the classification of the employee on the date of death.

Extension of coverage by making Voluntary Contributions is also subject to the following rules:

> Voluntary Contributions can only be made by active participants working at the trade, those participants who have become disabled, or those who have retired, or by surviving dependents of participants who die while eligible for benefits. If the Trustees become aware of the fraudulent use of the privilege of making Voluntary Contributions, by individuals or groups of individuals, the Trustees, in their sole discretion, may terminate this privilege for those individuals or groups of individuals.
>
> Voluntary Contributions can only be made for the Benefit Period immediately following the Work Period in which such person has failed to earn the required Employer Contributions. No advance payments will be accepted.

COBRA CONTINUATION COVERAGE

You and/or your eligible dependents also have the right under Federal Law to continue group health coverage under this Plan (called “COBRA continuation coverage”) for up to 18 months if you terminate your employment for any reason other than gross misconduct, or if you lose eligibility due to a reduction in hours. If you or your eligible dependent is determined by Social Security to be totally disabled at the time of the initial 18-month qualifying event, the disabled individual may keep COBRA coverage for up to 29 months, as long as proof of a Social Security disability award is furnished to the Medical Plan Office within sixty (60) days of the determination. The affected individual must also notify the Medical Plan Office within thirty (30) days of any final determination that the individual is no longer disabled.

If your spouse and/or dependents are receiving COBRA continuation coverage for the 18-month period and another qualifying event occurs, such as your death or a divorce, your spouse and/or dependents are eligible to have their coverage extended to a total of 36 months from the date of the initial loss of eligibility. If you should die, become divorced or legally separated, or become

entitled to Medicare, and your spouse and dependents are covered under this Plan at that time and lose their coverage, they will also be entitled to COBRA continuation coverage under this Plan for up to 36 months. In addition, COBRA continuation coverage is available for your unmarried children for up to 36 months after they no longer qualify as dependents, if they are not covered under another group health plan.

If you have not earned sufficient Employer Contributions during a Work Period to maintain eligibility, you have the option of making Voluntary Contributions during the Lag Period, subject to the rules for Voluntary Contributions described above, or making self-payments under COBRA continuation coverage. If you retire, you also have the option of making the Voluntary Contributions required for retirees or making self-payments under COBRA continuation coverage. Should you die while you and your dependents are eligible for coverage under the Plan, your dependents will have the option of making Voluntary Contributions or making self-payments under COBRA.

COBRA continuation coverage will be the same health coverage you and your dependents had when you were eligible for coverage under the Plan rules. However, the life insurance, the accidental death and dismemberment coverage, and the weekly disability benefit will not be available under COBRA continuation coverage.

Full details of COBRA continuation coverage and any other options available will be furnished to you and your dependents when you are about to lose eligibility for coverage for any of the reasons mentioned above.

You or your spouse or dependents must notify the Medical Plan Office within sixty (60) days of your divorce, legal separation or when a dependent child loses eligibility. If notification does not occur within this sixty (60) day period, you and your dependents will not be eligible for COBRA continuation coverage. If you terminate employment, have a reduction in hours, die or become entitled to Medicare and lose eligibility, your Employer is required to notify the Medical Plan Office and you will be informed of your continuation rights. However, if any of these three (3) events does occur, you should notify the Medical Plan Office as well.

The law permits the Plan to charge any person who elects COBRA continuation coverage up to 102% of the full cost to the Plan. If the cost changes, the Plan will revise the self-payment amount you are required to pay, but this change will not occur more than once every twelve (12) months. In the case of those who receive extended coverage for 29 months due to total disability the Plan is permitted to charge up to 150% of the cost for those additional 11 months.

Regardless of which continuation period applies, COBRA provides that an individual’s continuation coverage may be cut short for any of the following reasons:

a) Self payments are not paid on time;

b) The individual being continued becomes covered under another group health plan as an employee, spouse or dependent child and the other plan does not contain any exclusion or limitation with respect to you or your dependent’s pre-existing condition;

c) The individual being continued becomes entitled to Medicare, or

d) The group health plan terminates as to the eligible group of which you are or were a member. If the coverage is replaced, you may be continued under the new coverage.

FAMILY AND MEDICAL LEAVE ACT

The Family and Medical Leave Act of 1993 (FMLA) creates a new federal right for you to take up to 12 weeks of unpaid leave for your serious illness, after the birth or adoption of a child, or to care for your seriously ill spouse, parent or child.

The Family and Medical Leave Act applies to Employers if they employed 50 or more employees for each working day during each of 20 or more work weeks in the current or preceding calendar year.

To be eligible for FMLA benefits, you must:

- work for a covered Employer;
- have worked for the Employer for at least 12 months;
- have worked at least 1,250 hours over the previous 12 months; and
- work at a location where at least 50 employees are employed by the Employer within 75 miles.

A covered Employer must grant up to a total of 12 work weeks of unpaid leave during any 12-month period for one (1) or more of the following reasons:

- for the birth or placement of a child for adoption or foster care;
- to care for an immediate family member (spouse, child or parent) with a Serious Health Condition; or
- to take medical leave when you are unable to work because of a Serious Health Condition.

Spouses employed by the same Employer are jointly entitled to a combined total of 12 work weeks of family leave for the birth or placement of a child for adoption or foster care, and to care for a child or parent (but not a parent-in-law), who has a Serious Health Condition.

Leave for birth or adoption (including foster care placement) must conclude within twelve (12) months of the birth or placement.

Under some circumstances, you many take FMLA leave intermittently — which means taking leave in blocks of time, or by reducing your normal weekly or daily work schedule.

- Where FMLA leave is for birth or placement for adoption or foster care, use of intermittent leave is subject to the Employer’s approval.
- FMLA leave may be taken intermittently whenever it is medically necessary to care for a family member’s Serious Health Condition, or because you have a Serious Health Condition and are unable to work.

“Serious Health Condition” means an illness, injury, impairment, or physical or mental condition that involves:

- any period of incapacity or treatment connected with inpatient care (e.g., an overnight stay) in a hospital, hospice, or residential medical care facility;
- any period of incapacity requiring absence of more than three (3) calendar days from work, or other regular daily activities that also involves continuing treatment by (or under the supervision of) a Health Care Provider; or
- continuing treatment by (or under the supervision of) a Health Care Provider for a chronic or long-term health condition that is incurable or so serious that, if not treated, would likely result in a period of incapacity of more than three (3) calendar days, for prenatal care.

“Health Care Provider” means:

- doctors of medicine or osteopathy authorized to practice medicine or surgery by the state in which the doctor practices; or
- podiatrists, dentists, clinical psychologists, optometrists, and chiropractors (limited to manual manipulation of the spine to correct subluxation as demonstrated by x-ray to exist) authorized to practice, and performing within the scope of their practice, as defined under state law; or
- Christian Science practitioners listed with the First Church of Christ Scientist in Boston, Massachusetts.

A covered Employer is required to maintain health coverage for you on FMLA leave equivalent to the coverage that was provided before the leave was taken and on the terms as if you had continued to work.

A covered Employer must continue to make contributions on your behalf while you are on FMLA leave as though you are continuously employed.

Upon return to work from FMLA leave, you must be restored to your original job, or to an equivalent job with equivalent pay, benefits, and other employment terms and conditions.

Your use of FMLA leave cannot result in the loss of any employment benefit that you earned or were entitled to before going on FMLA leave.

The obligation to maintain health care coverage during an FMLA leave ends on the earliest of:

- when you return to work; or
- when 12 weeks or FMLA leave ends.

You need not accrue additional benefits or seniority during an unpaid FMLA leave, but you cannot lose benefits that accrued before a leave.

Welfare benefits, other than health care, must be reinstated when you return to work, without any new conditions or the requirement to re-qualify.

If you seek FMLA leave, your Employer may require you to provide:

- thirty (30) days advance notice of your need for FMLA leave when the need is foreseeable;
- medical certifications supporting your need for leave due to Serious Health Condition affecting you or an immediate family member;
- second or third medical opinions and periodic recertification (at your Employer's expense) and periodic reports during FMLA leave regarding your status and intent to return to work.

When leave is needed to care for an immediate family member or for your own illness, and is planned medical treatment, you must schedule treatment so that it will not unnecessarily disrupt your Employer's operations.

You and your Employer must certify to the Trustees, in writing, that you have been granted FMLA leave in order to protect your rights to health care coverage during the 12-week period.

If you and your Employer have a dispute over your eligibility and coverage under FMLA, your benefits will be suspended pending resolution of the dispute. The Trustees will have no direct role in resolving such a dispute.

CLASSIFICATION OF PARTICIPANTS

Listed below are the various Classes of Participants covered by the Plan. To determine your eligibility for benefits you must first determine your classification, and then refer to the Schedule of Required Contributions on page 24. Note that this classification will be determined as of March 1 and September 1 of each year and this will determine the level of benefits that you receive. This will apply to all situations except Disabled and Early Retirees who are turning age 65. In such instances, the required contributions will be pro-rated and the level of benefits will be determined accordingly. This schedule shows the amount of contributions you must earn, and/or the amount of the Voluntary Contributions you must make, if necessary, in order to be eligible for benefits.

Employees Working at the Trade—

Those participants who are working, or available for work, with a Participating Employer within the geographic area of the Plan and who are performing work specifically assigned to the Carpenters Trade under the terms of a Collective Bargaining Agreement. Work in another jurisdiction for which contributions are being paid to this Plan according to a Reciprocal Agreement

is considered work within the geographic area of the Plan.

Apprentices Working at the Trade—

Those participants who are registered and identified as Apprentices under an approved Apprenticeship-Training Program sponsored by a Participating Craft (Union) of the Western Pennsylvania Regional District Council of Carpenters, and who are working or available for work at the trade.

Self-Employed Participants—

Those participants who have signed an Agreement with the Western Pennsylvania Regional District Council of Carpenters and who are performing work assigned to the Carpenters' Trade within the geographic area of the Plan.

Office, Supervisory or Managerial Employees—

Those participants employed by a Participating Employer or Craft (Union) on whose behalf such Participating Employer or Craft (Union) has a written Agreement requiring contributions to be paid on behalf of all such employees to the Carpenters' of Western Pennsylvania Medical Plan.

Temporarily Disabled Participants—

Those employees normally working at the trade, who become temporarily disabled and unable to work as a result of a physical injury or illness which occurs while they are eligible for benefits under the Plan.

Permanently Disabled Participants Under Age 65—

Those participants under age 65, who worked at the trade and became totally and permanently disabled while eligible for benefits under the Plan and who are awarded a Disability Retirement Benefit under the Carpenters' Pension Fund of Western Pennsylvania.

Employees Temporarily Working
Outside the Geographic Area of the Plan—

Those members of a participating Local Union who, while working at the trade, are temporarily employed outside the geographic area of the Plan. Such participants may continue to maintain their eligibility for benefits through Voluntary Contributions for a maximum of four (4) consecutive Benefit Periods, provided they have not gained eligibility under another plan and they are working for Contributing Employers who are making contributions to other carpenter plans.

Retirees Age 55 But Under Age 65—

Participants who retire from the industry after attaining age 55, but prior to age 65, and who are receiving Early Retirement Benefits from either the Carpenters' Pension Fund of Western Pennsylvania or the Social Security Administration. Note that Permanently Disabled Participants not qualifying for coverage under the Permanently Disabled Participant category (e.g., not eligible for Medical Coverage in the period the disability began) may qualify for coverage under this category if they meet all requirements of Early Retiree participation, with the exception of the age requirement.

Senior Retirees (Age 65 and Over)—

Those participants who are age 65 or over and who are receiving Retirement Benefits from the Carpenters' Pension Fund of Western Pennsylvania, Social Security, or a similar retirement plan.

SCHEDULE OF REQUIRED CONTRIBUTIONS

PARTICIPANT CLASSIFICATION	EMPLOYER CONTRIBUTIONS REQUIRED PER WORK PERIOD	IF EMPLOYER CONTRIBUTIONS ARE INSUFFICIENT: TOTAL EMPLOYER AND/OR VOLUNTARY CONTRIBUTIONS REQUIRED PER BENEFIT PERIOD
EMPLOYEES WORKING AT THE TRADE	$1,570*	Initial Eligibility $1,800
APPRENTICES WORKING AT THE TRADE		Continuing Eligibility:

First Two Periods ....
$1,570 each period*

Next Two Periods..
$1,800 each period

Voluntary Contributions Limited to Four
Consecutive Benefit Periods

SELF-EMPLOYED PARTICIPANTS.. $2,100 $2,100

OFFICE, SUPERVISORY, or MANAGERIAL EMPLOYEES................. $2,100 Voluntary Contributions Not Permitted

TEMPORARILY DISABLED PARTICIPANTS.. $1,570* FIRST TWO PERIODS OF DISABILITY......
....$1,570 each period*

(Less any Disability Credits)

Each Benefit Period Thereafter...................
$1,800

PERMANENTLY DISABLED PARTICIPANTS— Not Applicable $360 Per Benefit Period for Retiree Only Coverage

(Under Age 65 entitled to $720 Per Benefit Period for Retiree and Dependent
Coverage

Participation in Disabled Retiree Program)..

EMPLOYEES TEMPORARILY WORKING Not Applicable $1,570 Per Benefit Period*

OUTSIDE GEOGRAPHIC AREA OF THE FUND .... Limited to Four Consecutive Periods

(Proof of employment in Trade required)

RETIREES AGE 55 BUT UNDER AGE 65 .... Not Applicable First Two Benefit Periods............................
....$1,570 each period*

Each Benefit Period Thereafter...................
$1,800

SENIOR RETIREES (AGE 65 AND OVER)... Not Applicable $360 Per Benefit Period for Retirees Only Coverage

$720 Per Benefit Period for Retiree and Dependent
Coverage

*The amount indicated is for the Benefit Period commencing October 1, 1999. Future eligibility levels will be based on 500 hours of employment at the majority journeyman's rate.

COORDINATION OF BENEFITS

Coordination of Benefits provides a framework for coordinating payment of medical expenses when you and other members of your family are covered by two (2) or more group benefit plans. For example, if your spouse has coverage under a group benefit plan sponsored by his or her employer and is also covered under this Plan, then you and your dependents may be eligible for benefits under both your spouse's plan and this Plan.

Coordination of Benefits provides for complete payment of your allowable expenses while preventing duplicate payment for the same service. Although Coordination of Benefits does not guarantee 100% reimbursement for all expenses, it does attempt to provide as close to 100% reimbursement as the plans involved in coordination allow.

The Medical Plan needs the assistance of all covered Carpenters to assure that claims for services which are the responsibility of other health insurance programs are paid by the proper program. It is important that the Medical Plan be advised if another family member has health insurance coverage through their employment. To avoid delays, if your spouse's plan is the primary plan for a claim under the rules described below, be sure to submit the claim to the primary plan first.

RULES FOR COORDINATION OF BENEFITS

If a person is covered under two (2) group benefit plans, the following rules are used to determine which plan pays first as the primary plan. The plan which is primary pays benefits without regard to coverage under other plans.

1. The plan which covers a person as an employee is the primary plan, and pays its benefits first. Any plan which covers a person as a dependent pays benefits second.

EXAMPLES:

You and your spouse are covered by two (2) different plans because you are both employed separately. Under Coordination of Benefits, this Plan pays first for you, and your spouse's plan pays first for him or her. Your spouse's plan may cover any remaining eligible bills for you, while this Plan may cover any remaining bills for him or her.

A. You have $1,000 in medical bills which are considered covered expenses under both plans. This Plan covers a maximum of $800 in expenses. Your spouse's plan will coordinate with your Plan to provide coverage up to a $200 maximum, which is the remaining amount of the expenses.

B. Your spouse has $1,200 in medical bills which are considered covered expenses under both plans. Your spouse's plan covers a maximum of $900 in expenses. This Plan will coordinate with your spouse's plan to provide coverage up to a $300 maximum, which is the remaining amount of expenses.

2. The plan which has no Coordination of Benefits provision will pay its benefits first as the primary plan.

3. A plan which covers a person other than as a laid-off or retired person, or as a dependent of such person, will pay its benefits before the plan which covers the person as a laid-off or retired person, or as a dependent of such person. This rule shall not apply if the other plan does not have a Coordination of Benefits provision regarding laid-off or retired persons.

4. If a dependent child is covered by both parents' benefit plans, the plan of the parent whose birth date (month and date only) occurs earlier in the calendar year will pay first. The other plan will coordinate to pay second. This is known as the "birthday rule".

EXAMPLE:

You and your spouse are both covered by different plans. Your birth date is September 15, and your spouse's birth date is November 30. Under the birthday rule, your plan pays benefits for your dependent children first, with your spouse's plan paying second.

Your ten-year-old son is covered as a dependent under both plans, and has incurred medical bills of $740 which qualify as covered expenses under both plans. Benefits payable under your plan total $600. Under Coordination of Benefits using the birthday rule, your Plan pays $600 first, and your spouse's plan will coordinate with your Plan to provide coverage for up to $140 in remaining bills.

However, if the other plan does not utilize the birthday rule, but instead uses a gender-based rule to determine which plan pays first, the gender-based will determine the order of plan benefit payments in both plans. The gender-based rule is a rule which designates the male employee's plan as first responsible for a dependent child's expenses.

SPECIAL RULES FOR DEPENDENT CHILDREN

If a dependent child whose parents are separated or divorced is the patient, benefits will be paid as follows:

The plan which covers a child of a parent who has financial responsibility for health care expenses of the child through court decree will be the primary plan and pay benefits first.

If there is no court decree:

- the plan of the parent with custody pays first,
- the plan of the spouse of the parent with custody (i.e., the stepparent) pays second, and
- the plan of the parent without custody pays last.

5. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee longer are determined before those of the plan which covered that person for the shorter term.

If the husband or wife of an eligible employee is enrolled in or chooses to join a health maintenance organization and then fails to use that program, this Health and Welfare Fund will not be responsible for providing benefits to that individual, because the health maintenance organization will be considered fully responsible for the health care needs of that person.

The purpose of Coordination of Benefits is to assure that, between this Plan and a plan that covers your spouse as an employee, you will receive full reimbursement for covered medical expenses, after payment of any applicable deductibles. The following examples are provided to help you understand your rights under this Plan when both you and your spouse have health insurance.

EXAMPLE 1:

If your wife has a health insurance program through her employer which has a $100 calendar year deductible, and she incurs $300 in prescription drug expenses, it is her employer’s responsibility to make the first payment with respect to her health insurance claim. After the $100 deductible, her employer’s plan would normally pay 80% of the $200 balance, or $160.

Your Plan provides for a separate prescription drug benefit with a $50 deductible. The same $300 of prescription drugs expenses are then submitted to the Carpenters’ of Western Pennsylvania Medical Plan. Under normal circumstances, this Plan would pay, after the $50 deductible, 80% of the $250 balance. Accordingly, this Plan would normally pay $200. However, as your wife’s health insurance program has already paid $160, that payment will be taken into account. It is the intent of this program to see that your expenses are covered at 100% after the $50 deductible. Therefore, this Plan will subtract the $50 deductible and the $160 payment made by your wife’s program, and then pay $90. Between the two programs, you will have received $250, and your out-of-pocket expense is limited to $50.

EXAMPLE 2:

In additional to these prescription drug expenses, your spouse is likely to be seeing a doctor on a regular basis. Over the course of a year, she may see a doctor once every six weeks, and the doctor’s charge may be $75 per visit. This would result in additional expenses of $600 for the eight (8) office visits. Under her employer’s program your spouse would be reimbursed 80% of $600 or $480.

This plan provides payment for office visits for treatment of an illness after a $100 per eligible person office visit deductible has been satisfied. Because your spouse’s plan has already paid $480 dollars of eligible expenses the plan would examine the $120 in remaining eligible expenses and pay $20. The only amount not covered would be the $100 office visit deductible.

COORDINATION WITH MEDICARE (Part A and Part B)

The Plan will pay its benefits before Medicare ONLY for:

1. An active employee who is age 65 or older;

2. An active employee's dependent spouse who is age 65 or older;

3. The first 18 to 21 months of treatment for end-stage renal disease received by any covered person; or

4. Medicare beneficiaries who are disabled and are covered as a result of their current employment status, or the current employment status of a family member.

When the rules above do not apply, the Plan will pay its benefits only after Medicare has paid its benefits.

IMPORTANT

If you are eligible for Medicare, the Plan will pay benefits only up to the amount that would be paid under the above rules, whether or not you have applied for Medicare benefits. Because your benefits under this Plan may be affected by Medicare, you may want to contact your local Social Security Office for information about Medicare. This should be done before you or your spouse's 65th birthday. Anyone eligible for Medicare must be enrolled in Medicare Parts A and B, or benefits will not be paid.

COORDINATION WITH HMO, PPO AND POS PLANS

If this Plan is secondary, and if the coordinating primary plan does not cover the health care services because they were obtained out-of-network, benefits for those services will not be covered by this Plan. It is very important to understand that failure to use in-network services provided by an HMO or network plan may result in no coverage for services under both that HMO or network plan and this Plan.

SUBROGATION

This Plan will take advantage of its right to subrogation if you or your dependent are paid benefits for expenses due to accidental injuries for which someone else may be liable.

Subrogation means that the Plan can regain from the person who caused the injury, or that person's insurance company, the benefits paid on your behalf for that injury, including, but not limited to, claims compensable under state workers' compensation laws, medical malpractice or tortuous conduct by a third (3rd) party. However, the Plan shall have no right of subrogation against an insurance company arising out of an individual policy of insurance maintained by you.

Your claims and benefit payments will normally continue to be paid in the same way as they always have been. However, you or your dependent will have certain responsibilities to the Plan. When you or your dependent submit a claim for injuries, the Administrative Office will have you complete a form requesting information as to how the injuries occurred and the identity of any potentially responsible third (3rd) parties. At the request of the Administrative Office, you must also sign any other documents and do whatever else is reasonably necessary to secure the Plan's Right of Subrogation. You must not do anything to impair or negate this Right of Subrogation, and if any of your acts or omissions to act compromise this Right of Subrogation, the Plan will seek reimbursement of all appropriate benefits paid directly to you and/or your eligible dependents.

ADMINISTRATIVE PROCEDURES AND CLAIMS PROVISIONS

EMPLOYEE IDENTIFICATION CARD

Every participant must submit a completed Employee Identification Card which may be obtained by calling or writing the Administrative Office. A new card must be completed when you change your address, marital status, beneficiary, or dependents. You will be held responsible for any loss suffered by the Plan because of your failure to report a change in status.

CHANGE IN FAMILY STATUS

It is important that you give prompt written notice to the Administrative Office of any change in your family status, such as marriage or divorce, the birth of a child, the marriage of any of your enrolled children, or death of any dependent.

If you are enrolled for individual coverage only and thereafter marry or otherwise acquire a dependent, dependent coverage will become effective on the date you acquire the dependent, provided you notify the Administrative Office of the change in status. *Retirees, please refer to the section on Eligibility for Dependents.*

When adding new dependent children for the first time, please provide us with a copy of the birth certificate or birth registration. When changing marital status or beneficiaries, a marriage certificate and/or divorce decree will be required. For a common law marriage, a notarized statement along with other proofs will be required. Medical coverage for a spouse and dependents acquired through a common law marriage will not be made retroactive beyond the date proper notification is received and accepted by the Administrative Office.

CLAIMS FOR BLUE CROSS-BLUE SHIELD BENEFITS

For Hospital and Doctor Expense Benefits provided by Blue Cross-Blue Shield, simply present your Blue Cross-Blue Shield Identification Card to the admitting clerk of the hospital, or your doctor’s secretary, at the time you enter. No credit references are required with Member Hospitals or participating doctors.

Please refer to the Blue Cross-Blue Shield section of this booklet for further information on filing claims, payment of Blue Cross-Blue Shield benefits, and procedures for appealing claims denied by Blue Cross-Blue Shield.

CLAIMS FOR SELF-INSURED BENEFITS

(Excluding Death Benefits)

Benefits under the Medical Plan which are not provided by Blue Cross-Blue Shield are self-insured by the Plan. In those situations where services provided by a physician or other licensed service provider are not specifically excluded by Pennsylvania Blue Shield, the participant must file a claim with Blue Shield for consideration before it is submitted to the Medical Plan for reimbursement. Certain services are clearly excluded under the description provided by Blue Shield and are covered directly by the Medical Plan. Those claims should be submitted directly to the Plan Office for reimbursement.

When you file a claim for self-insured benefits, written proof of expense must be furnished to the Plan Office within ninety (90) days from the date of service. Proof of service shall consist of the completed Claim Form, together with all itemized bills or other documents called for under the Plan, signed and certified to by the claimant, or in the case of death, by his or her beneficiary.

Failure to furnish notice or proof within ninety (90) days shall not invalidate or reduce a claim if it can be shown that such notice or proof was furnished as soon as was reasonably possible. However, in no event will claims be honored if the year the expense was incurred is different by more than one (1) year from the year the claim is received in the Plan Office. For example,

during 1999, only claims incurred in 1998 and 1999 will be honored. No claim from 1997 or any prior year will be accepted for payment.

PAYMENT OF SELF-INSURED BENEFITS

Self-insured benefits under the Plan will be paid directly to the eligible participant, unless the participant has assigned such benefit payments to a provider of service. However, in no event may the participant assign Death, Accidental Death Benefit or Weekly Disability Benefits under this Plan.

In the event that benefits are payable to an eligible participant who is deceased, these benefits will be paid to the named beneficiary, if living, unless the eligible participant has assigned such benefit payments to the provider of the service for which the benefits are being paid. In that case, the benefit payment will be made first (1st) to the provider of the services, and any remainder shall then be paid to the named beneficiary, if living. If the beneficiary is not living, the benefits shall be payable to the first (1st) surviving class of the following classes of successive beneficiaries:

1. widow or widower;
2. surviving children;
3. surviving parents;
4. surviving brothers and sisters;
5. estate of the participant.

DENIAL OF CLAIMS AND APPEAL PROCEDURES

Any participant whose claim is denied will be notified of the denial in writing, and the notice will set forth the basis for the denial. A participant whose claim has been denied may appeal to the Trustees for reconsideration and review of his claim. Such appeal need not be formal, but must be made in writing and filed with the Trustees within sixty (60) days from the date the denial notice was received. The appeal should set forth the reasons the claimant believes his claim should be paid. The appeal will then be reviewed by the Trustees at the next regular meeting. The Trustees will then decide the merits of the claim. If the appeal is rejected, the claimant will be given written notice.

Should the claimant dispute the decision of the Trustees, he may request a formal hearing by the Trustees Claims Appeal Committee, at which time he can present any additional information, testimony or evidence to substantiate his claim. He may also be represented by counsel at the hearing. Further, the claimant will have the right to review all pertinent documents and records relating to this claim prior to the date of the hearing. Within thirty (30) days following the meeting, providing all the evidence and facts have been substantiated, the Trustees will render a final decision which will be communicated to the claimant.

ERRORS IN BENEFIT PAYMENTS

The Trustees specifically retain the right to recover all money paid in error to or on behalf of any person, from such person.

Upon the discovery of the payment made in error, the Trustees will notify the recipient or beneficiary of the error, indicating the circumstances and amount of payment in error, together with a request for repayment. If the recipient fails to repay the amount due within a reasonable time after such notification, the Trustees may take whatever legal action they deem necessary. In the case of a Plan participant, the amount of payment made in error may be deducted from any future benefit payments that the participant or his dependents or beneficiary may become entitled to under this Plan.

FRAUD

Any person attempting to submit false, misleading or incomplete information, or who in any way attempts to defraud the Medical Plan, may be prosecuted in whatever manner the Trustees deem advisable.

TRUSTEES' RIGHT TO REQUIRE A PHYSICAL EXAMINATION

The Trustees, at their expense, shall have the right and opportunity to have any participant or dependent examined as often as is reasonably required during the pendency of a claim. If a claimant is notified to report to a physician designated by the Trustees for a physical examination and fails to do so without reasonable cause, at the Trustees' discretion the claimant may be disqualified from receiving further benefit payments.

TRUSTEES' RIGHT TO AMEND THE PLAN

In accordance with the Agreement and Declaration of Trust, the Board of Trustees are empowered to amend, alter, modify or terminate the plan of benefits for active or retired employees. Benefits under the Plan are not guaranteed. The Board of Trustees in their absolute discretion and in what they deem appropriate retains the right to modify or terminate benefits provided to retirees at any time.

TRUSTEES' AUTHORITY

The Plan Fiduciaries shall have the authority to interpret all Plan documents, construe all uncertain terms and determine eligibility on behalf of participants for all benefits.

EMPLOYEE DEATH BENEFITS

BENEFITS

Upon timely receipt by the Trustees of due proof that an eligible participant shall have died, the Trustees shall pay to the beneficiary of record the Death Benefits set forth in the Schedule of Benefits.

BENEFICIARY

It is MOST IMPORTANT that you designate the person to whom the proceeds of your Death Benefits are to be paid. You do this by filling in his or her name on the Plan Employee Identification Record which may be obtained by contacting the Plan Office. Upon WRITTEN REQUEST the beneficiary may be changed at any time and as often as desired. The designation of such beneficiary shall take effect upon receipt of such notice in the Plan Office. If the beneficiary dies before the eligible participant, the interest of such beneficiary shall thereupon terminate unless otherwise provided by such written notice.

If there is no beneficiary designated or surviving at the death of the eligible participant, payment will be made in a single sum to the first (1st) surviving of the following classes of preferential beneficiaries:

(a) the widow or widower;

(b) the surviving children;

(c) the surviving parents;

(d) the surviving sisters and brothers;

(e) the executors or administrators of the estate.

FILING FOR DEATH BENEFITS

Written proof of the death of an eligible participant must be filed at the

Plan Office by the claimant within one hundred twenty (120) days from the date of such event. Failure to furnish such proof within one hundred twenty (120) days shall not invalidate the claim if it shall be shown not to have been reasonably possible to furnish such proof within the time required. However, all liability on the part of the Plan and the Trustees shall cease and any person's claim to benefits shall be forfeited unless notice and the required proofs are submitted within thirty-six (36) months from the date of death.

PAYMENT OF DEATH BENEFITS

The Trustees reserve the right to pay all Death Benefits in a single sum, or such other manner as they may deem advisable to the designated beneficiary or lawful claimant within twelve (12) months from the date of receipt of the required proof, it being expressly understood that no interest will accrue to the principal benefit of the claimant during the period between the date of death and the date of the benefit payment.

ASSIGNMENT OF DEATH BENEFITS

No assignment by an eligible participant of the Death Benefits under this Plan shall be valid.

DEPENDENT DEATH BENEFITS

Upon timely receipt by the Trustees of due proof that an eligible dependent (as hereinafter defined) shall have died, the Trustees shall pay to the surviving Active (covered) Employee the Death Benefit set forth in the Schedule of Benefits. If there is no surviving Active Employee at the time of death of the eligible dependent, payment will be made to the first (1st) of the following classes of preferential beneficiaries if living:

(a) the employee's lawful spouse;

(b) the employee's surviving child or children;

(c) the employee's surviving parents;

(d) the employee's surviving brothers and sisters;

(e) the employee's estate, or to any other person appearing to the Trustees to be equitably entitled to the same by reason of having incurred expense on behalf of the eligible dependent for his or her burial.

DEFINITION OF ELIGIBLE DEPENDENTS

Eligible dependents for the purpose of this provision are defined as:

(1) an eligible Active Employee's lawful spouse; and

(2) an eligible Active Employee's unmarried child or children (including step-children and legally adopted children) provided they are:

- (a) dependent upon eligible Active Employee for support and maintenance, and
- (b) over 180 days of age and under 19 years of age, except unmarried dependent children age 19 or over shall also be construed to mean student children to age 23 while they are attending on a full-time basis, a high school, college, university, trade or training school.

FILING FOR DEPENDENT'S DEATH BENEFITS

Written proof of the death of an eligible dependent must be filed at the Plan Office by the claimant within one hundred twenty (120) days from the date

of such event. Failure to furnish such proof within one hundred twenty (120) days shall not invalidate the claim if it shall be shown not to have been reasonably possible to furnish such proof within the time required. However, all liability on the part of the Plan and the Trustees shall cease and any person's claim to benefits shall be forfeited unless notice and the required proofs are submitted within thirty-six (36) months from the date of death.

PAYMENT OF DEPENDENT'S DEATH BENEFITS

The Trustees reserve the right to pay all Death Benefits in a single sum, or in such other manner as they deem advisable, to the lawful claimant within twelve (12) months from the date of receipt of the required proof, it being expressly understood that no interest will accrue to the principal benefit of the claimant during the period between the date of death and the date of benefit payment.

ASSIGNMENT OF DEPENDENT'S DEATH BENEFITS

No assignment by an eligible employee or dependent of the Death Benefit payable hereunder shall be valid.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

FOR EMPLOYEES ONLY

If, while eligible for coverage under the terms of the Medical Plan, you sustain any of the following losses solely through external, violent and purely accidental means, the indicated benefits are payable to the eligible participant if living, otherwise to his beneficiary.

Loss of Life...................... Maximum Benefit

Loss of two limbs, sight of both eyes, or
loss of one limb and sight of one eye Maximum Benefit

Loss of one limb or
sight of one eye....... One-Half of the Maximum Benefit

"Maximum Benefit" as used herein, refers to the amount set forth in the Schedule of Benefits for the Class of Benefits in which the participant was eligible at the time of loss.

Loss must occur within three hundred sixty-five (365) days from the day of the accident.

Loss of limb means dismemberment by severance at or above the wrist or ankle joint. Loss of sight means the total and irrecoverable loss of sight.

If more than one (1) of the losses set forth above is suffered as the result of any one (1) accident, not more than the Maximum Benefit will be payable.

No benefits are payable for death or for any loss caused by or resulting from:

- ptomaines or bacterial infection (except pyogenic infection which shall occur through an accidental cut or wound); or
- bodily or mental infirmity, sickness or disease; or
- suicide or attempted suicide and intentionally self-inflicted injury while sane or insane; or participation in the committing of a felony.

ASSIGNMENT — No assignment by an eligible employee of the benefit payable hereunder

shall be valid.

EMPLOYEE WEEKLY DISABILITY BENEFITS

The weekly disability benefit, Two Hundred Dollars ($200.00), will be payable to you if, while covered under the Plan, you become disabled and unable to work because of a non-occupational accident or sickness. Injuries or sickness sustained on the job or which are compensable under Workers' Compensation are not covered.

Benefits will begin as of the eighth (8th) day of a disability and will be limited to a maximum of fifteen (15) weeks during any one (1) period of disability.

Successive periods of disability separated by less than two hundred (200) hours of employment shall be considered as one (1) continuous period of disability unless they arise from different and unrelated causes. If you have a different and unrelated disability, and return to work for one (1) full day, you will then be entitled to a new Benefit Period.

You do not have to be confined to your home to collect benefits, but you must be under the regular care and attendance of a legally qualified physician or surgeon. No disability will be considered as beginning prior to the first (1st) visit or treatment by a physician.

DISABILITY PAYMENTS

To qualify for weekly disability benefits, disabled employees must submit a completed claim form. The employee's attending physician must certify on this form that the employee was totally disabled from his occupation and show the date of all examinations and treatments.

The Trustees reserve the right to have any claimant for weekly disability benefits referred to a physician of their choice for examination or re-examination. Failure without good excuse to report to the Plan's physician within forty-eight (48) hours after notice to do so may result in suspension of disability payments.

Disability payments will normally be paid for the period certified on the claim form by the doctor. In order to receive additional payments for continuing periods of disability, the employee must submit Continuance of Disability Claim Forms to the Plan Office.

Persons receiving either:

(1) Retirement, Early Retirement or Disability Retirement Benefits from an Industry Pension Fund;

(2) Unemployment Compensation Benefits; or

(3) Workers' Compensation Benefits,

are not eligible for disability benefits under this Plan. Under no circumstances will the time period that a member collects Unemployment Compensation Benefits be counted toward the period of disability. However, if there is a loss of Unemployment Compensation as a result of illness or non-occupational injury, you may then be entitled to collect this benefit from the point in time the Unemployment Compensation ceased.

MEMBERSHIP ASSISTANCE PROGRAM (MAP)

All members of the Western Pennsylvania Regional District Council of

Carpenters are eligible to use the Membership Assistance Program (MAP). Your MAP provides you and your family with free and confidential help in dealing with personal problems.

MAP is designed to provide prompt, professional help for you and your eligible dependents experiencing personal problems, such as stress, marital difficulties, child or adolescent concerns, death or illness of a family member, financial pressure, or job stress to name a few. While these are "human problems" that anyone may experience at any time, knowing where to turn for help can be difficult. This membership assistance program operates on a completely confidential basis with you and your eligible dependents. All services provided by this program are strictly confidential, no information can be released without your written permission.

The Carpenters of Western Pennsylvania Medical Plan has contracted with Lytle Behavioral Health to provide Membership Assistance Program Services to you and your family. Lytle Behavioral Health is an organization of counselors, social workers, and other professionals who will provide assessment of problems, short-term counseling, and when appropriate, referrals for treatment with clinical specialists who are located near you. Access to Lytle Behavioral Health's providers is excellent. You can contact your Membership Assistance Program directly at (888) MAP-6637 or (888) 627-6637.

You will be eligible to receive up to six (6) visits with a counselor at no cost to you or your eligible dependents. The assessment, short-term counseling and referral services are absolutely free and confidential.

The Trustees believe that this program is a winning situation for everyone. Members and their families have access to a needed valuable benefit and our Employers will have access to a healthier, safer and a more stable workforce. Our Medical Plan will also benefit by providing a program to assist members to resolve personal problems before they develop into conditions that require medical attention.

SELF-INSURED SUPPLEMENTAL MEDICAL SERVICES PAYABLE THROUGH CARPENTERS' COMBINED FUNDS, INC.

See schedules on pages 1 through 5 to determine which benefits apply to you and your dependents

If you or one of your dependents incur expenses for one of the following "covered medical expenses" as a result of a non-occupational injury or illness while eligible hereunder, the Medical Plan will (subject to the terms and conditions hereafter stated) reimburse you on the basis of:

(a) eighty percent (80%) of the usual and customary fee for "covered medical expense" rendered in connection with the treatment of the injury or illness; or

(b) fifty percent (50%) of the usual and customary fee in connection with the outpatient treatment of a mental or nervous disorder, limited to a maximum of 35 outpatient visits per calendar year. These services must be provided directly by a licensed M.D., or psychologist. If these services are provided by a licensed therapist, social worker or other professional, they must be under the direct supervision of an M.D. or psychologist, or

(c) one hundred percent (100%) of the usual and customary fee for the services listed under oral surgery.

COVERED MEDICAL EXPENSES

1. Home and Office Medical Visits

If provided by a doctor of medicine, osteopathy or chiropractic, after a $100 per person annual deductible for the treatment of a physical injury or illness, subject to a maximum payment of $1,000 per calendar year. Any other services provided in connection with the visit do not result in waiving the requirement that payment will commence after a $100 per individual annual deductible. Dental exams, consultations and office visits are not covered.

2. Blood or Blood Plasma

Payment will be made provided there is a charge made which the patient is required to pay. No payment will be made for the first three (3) pints of blood, or for blood or blood plasma which has been replaced, donated or provided by a blood bank for which no payment is required of the patient.

3. Ambulance Service

Professional ambulance service where medically necessitated when used to transport the claimant directly from where he is injured or stricken by illness, either to a physician's office, clinic or hospital. Only one payment will be made per accident or illness. However additional payments may be made should it be necessary to transport an individual so that proper treatment can be received. Payment is limited to a maximum of $500 and is payable at eighty percent (80%) of the usual and customary charge for that service. Ambulance also includes Life Flight services which are necessary because of trauma and not covered as part of the hospital bill. Coverage is at 80% up to a maximum payment of $5,000.

4. Prescription Drug Expense

Once per year, at the beginning of each year, you will have a choice between the prescription drug program administered through the Combined Funds Office and the Giant Eagle Network Program. Both programs offer similar benefits. Each has a $50 per calendar year per individual deductible and a $3,000 per calendar year per individual maximum benefit.

Prescription drugs are defined as those:

(a) Prescriptions for drugs which require compounding.

(b) Prescriptions for legend drugs (drugs which cannot be dispensed without a prescription).

(c) Prescriptions for insulin.

The Medical Plan will not cover any drugs, diet supplements, vitamins, etc., which can be purchased without a prescription. In addition, the Medical Plan will not cover prescription drugs which are prescribed for cosmetic purposes. Prescription drugs to assist an individual to quit smoking are not covered. A written prescription by a physician for those items which do not require a prescription will not result in a covered medical expense. Birth control pills taken for contraceptive purposes are not a covered prescription drug.

Prescription Drug Program through Combined Funds, Inc.

The Program has a $50 per calendar year per individual deductible and a $3,000 per calendar year per individual maximum benefit. After the deductible is met, you will be reimbursed 80% of charges. This program allows you to make your purchases at any Pharmacy.

Prescription Drug Program
through Giant Eagle Network

The Program has a $50 per calendar year per individual deductible and a $3,000 per calendar year per individual maximum benefit. After the deductible is met, only one (1) copayment of $5 (or $2 for generic medications) is required for up to a 90-day supply of your medication. There are no claim forms to fill out. Our current contract with Giant Eagle requires that they charge us no more than the lower of usual and customary charges or average wholesale price less 15%. Note however, when you sign up for this Program, you must purchase your prescriptions at pharmacies listed in the Giant Eagle directory

of participating pharmacies. If you sign up for the Giant Eagle Program and do not purchase your prescription at a Giant Eagle Network Pharmacy, you will not be reimbursed for that prescription.

5. Private Duty Nursing Service

Provided when medically necessary and rendered by a registered graduate nurse or a licensed practical nurse and the need is medically certified by a doctor. Payment will not be made if the services are provided by an individual who is a relative of the participant receiving the service, by either blood or by marriage.

To the extent skilled home nursing care is exhausted under the Blue Cross contract, this benefit will include those services for the balance of the calendar year. This benefit is subject to a $100,000 lifetime maximum and cannot be restored.

6. Oxygen and the Rental of Equipment for its Administration

7. Oral Surgery

To the extent that the following services are not a covered expense under the surgical benefits provided by Pennsylvania Blue Shield:

(a) Simple extraction of diseased teeth. This does not include the dental examination. X-rays are covered up to a maximum of $50 per covered procedure.

(b) Root canal therapy. This does not include the dental examination. X-rays up to a maximum of $50 per covered procedure, post and core charges are covered. This does not include other services which may follow the root canal such as a cap or a crown.

(c) Osseous (bone) surgery in connection with periodontal disease. Gingivectomy, Gingival Curettage, Gingival Graft and Soft Tissue Graft are covered procedures. This coverage is limited to the itemized procedures and Scaling and Root Planing are not covered. X-rays are covered up to a maximum of $50 per covered procedure.

(d) X-rays, up to a maximum of $50 per covered procedure, in connection with the extraction of an impacted tooth. Proof of denial of the x-ray claim by Blue Shield is required.

No other services which would normally be considered as those provided under a dental expense program are to be covered.

8. Miscellaneous Supplemental Medical Benefits

If you or your dependents, while eligible for Active Employee coverage, incur expense for one (1) of the covered medical treatments listed below, the Plan will reimburse you, after you pay the first $50 during the calendar year, eighty percent (80%) of the usual and customary fee for all such services up to a maximum of $2,000 per calendar year. The expense must be for items which are not covered under the Blue Cross of Western Pennsylvania or the Pennsylvania Blue Shield contracts, and are medically appropriate for treatment of a non-occupational illness or injury.

Expenses covered under the Supplemental Medical Benefit are limited to:

- PUVA (ultraviolet therapy for psoriasis)
- EBI Bone Healing Systems (by osteogen treatment)
- Cardiac Exercise Therapy
- Intravenous Drug Therapy, including antibiotics
- Vision Therapy, including Visual Training and Visual Fields
- Speech Therapy — Non-education (must be related to a congenital defect, accident or illness i.e., stroke recovery)
- Thermography

The Plan requires a detailed medical explanation as to the need for this service by the physician or service provider and it is expected that the employee will assist in obtaining this information. The Plan shall require that

this information be reviewed to determine that the treatment is necessary and medically appropriate.

9. Outpatient Chemotherapy Provided in a Home Setting

To the extent chemotherapy would otherwise be administered on an inpatient basis, and the attending physician confirms the medical appropriateness of the treatment, this Medical Plan will reimburse the cost of supplies to self-administer treatment at the patient's or care giver's home. The reimbursement is not to exceed the cost of a semi-private room used for the same purpose for the period involved.

10. Durable Medical Equipment

The purchase or rental for prosthetic and orthotic appliances (other than dental) and equipment which is certified as medically necessary by your doctor. Repairs and service for these appliances or equipment are a covered expense, as are syringes and needles as required for the administration of insulin. Equipment and appliances to provide additional comfort are not covered. Equipment not of a strict medical nature, such as exercise equipment, bicycles, mattresses, massage chairs, waterbeds, whirlpool baths, saunas, etc., is not covered.

11. Hairpieces/Wigs

The cost of hairpieces for sudden loss of hair due to illness or injury will be covered under the Plan's Supplemental Medical Benefits, payable at 80% after a $50 deductible, up to a maximum of $500 per hairpiece, with a $1,000 lifetime maximum.

Loss of hair must be due to disease or local injury to the scalp from causes such as burns, radiation therapy, chemotherapy treatment, cobalt therapy or neurosurgery. The hair loss should be considered permanent in nature, or expected to last for at least one (1) year. Coverage will not be provided for hairpieces if hair loss is considered temporary, due to causes such as sudden high fever or shaving of the scalp for surgery.

In order to cover the cost of a hairpiece, the Plan must receive a written recommendation by the treating physician stating that the hair loss is expected to last at least one (1) year, and hairpiece is medically necessary.

12. Hearing Aids

Effective October 1, 1999, a hearing aid benefit is provided, payable through the Fund Office at 80%. The maximum reimbursement is $75 for the fitting and exam and $1,500 for the appliance. The benefit will be provided once every 36 months.

PLEASE NOTE: The self-insured benefits described above, which are provided directly by the Medical Plan, will not duplicate payment for any service or charge that is covered by either Blue Cross or Blue Shield or any other group health insurance plan which covers an eligible employee or dependent with whom this Medical Plan has contracted for services.

WHAT IS NOT COVERED

Any service that is not specifically listed in the Self Insured Benefit section as a covered expense will not be covered by the Plan.

Claims that are commonly submitted but not covered include treatments or services in conjunction with:

1. Weight loss programs of any type
2. In-vitro fertilization
3. Dental exams, consultations and office visits
4. Dental procedures such as Frenectomy, Pulpotomy, Acid Etch, Scaling and Root Planing
5. Supplies or appliances provided to alter, correct, fix, improve, remove, replace, reposition or restore the jaw, jaw implant or the joint of the jaw, the meeting of the upper and lower teeth or the chewing muscles

6. Gender dysphoria
7. Any cosmetic procedure
8. Any experimental procedure
9. Anything, including prescription drugs, to help someone stop smoking
10. Flu shots.

This listing is not intended to be all-inclusive. It is merely a listing of commonly submitted claims that are not covered.

GENERAL EXCLUSIONS AND LIMITATIONS

No benefits are payable for the following:

1. Treatment or service which is paid for or furnished by any government agency, unless a charge is made which the member is legally required to pay.

2. Services for which you are not legally obligated to pay, or services for which a charge would not be made except as a result of this insurance being in effect.

3. Expenses Incurred Because Services Were Provided Outside an HMO Network: Expenses incurred by a covered dependent (that is, the Spouse or any dependent child or an eligible employee) who is also covered by an HMO or other plan providing for in-network benefits for any covered medical services that are not covered by the HMO or network plan because the dependent received those services out-of-network.

It is very important to understand that this provision operates so that when an HMO or network plan excludes coverage for out-of-network services, no coverage for those services will be provided by this plan.

VISION CARE BENEFITS

For eligible persons age 19 and over, benefits are limited to one (1) examination and one (1) pair of glasses every twenty-four (24) months.

For eligible persons under age 19, benefits are limited to one (1) examination and one (1) pair of glasses every twelve (12) months.

SCHEDULE OF BENEFITS

Examination, Diagnosis and Prescription Allowance:	
When performed by Optometrist or Ophthalmologist	$ 40.00
Frames, Fittings and Lens Allowance:	
Single Vision	$ 90.00
Bifocal Lens	$100.00
Trifocal Lens	$110.00

The frames, fittings and lens allowance may be applied to contact lenses in lieu of glasses.

SUBNORMAL VISION CARE

Maximum Allowance Per Calendar Year	$200.00
Co-Insurance	
To be paid by Plan	80%
To be paid by Participant	20%

When an eligible participant or dependent’s visual acuity is not correctable to 20/70 in the better eye by use of conventional lenses, but can be improved up to 20/70 in the better eye by use of contact lenses, telescopic lenses or

other sub-normal vision aids, the Plan will pay eighty percent (80%) of all expenses incurred up to a maximum of $200 for such contact lenses, telescopic lenses or other sub-normal vision aids, as well as for professional services required to fit, administer, or otherwise prepare such sub-normal aids, providing such subnormal vision aids were recommended by an Optometrist or Ophthalmologist, acting within the usual scope of his license, and certified as being necessary and required to improve such a person's visual acuity in the better eye up to 20/70, but not to exceed the maximum as herein stated in any twelve (12) month period.

APPLYING FOR BENEFITS

You must call or write the Plan Office indicating that you wish to apply for Optical Benefits. When applying to the Plan Office, please give your full name, address and social security number and indicate whether the application for Optical Benefits is for yourself or your dependent. If it is for a dependent, be sure to state the name and age of the dependent. A separate application must be made for each person applying for Optical Benefits.

If eligible, you will then be sent a Certificate of Eligibility, which is to be presented to the Optometrist or Ophthalmologist for completion. This certificate must be signed in the presence of the Optometrist or Ophthalmologist at the time of presentation.

GENERAL EXCLUSIONS AND LIMITATIONS ON VISION CARE SERVICES

The Plan does not cover any loss or expense caused by, incurred for, resulting from:

1. Vision Care services or supplies furnished by or at the direction of the United States Government or any agency thereof, any state, territorial or commonwealth government or political subdivision thereof, or a foreign government agency thereof;
2. Sunglasses, plain or prescription, or safety goggles.
3. Vision Care services received prior to eligibility date.

LISTING OF GROUP NUMBERS

GROUP No. 51242-00
Active Employees and their Eligible Dependents

GROUP No. 51242-02
Early Retirees and their Eligible Dependents
who are not eligible for Medicare.
Also, Dependents of Medicare eligible Early Retirees.

GROUP No. 51242-04
Non-Medicare eligible Dependents of Senior Retirees

GROUP No. 51242-06
Disabled Retirees not yet eligible for Medicare.
Also, non-Medicare eligible Dependents of Disabled Retirees.

GROUP No. 51242-08
Dependent Children (not eligible for Medicare)
of Senior Retirees

GROUP No. 63242-01
Senior Retirees and their Medicare eligible Dependents

GROUP No. 63242-03
Disabled Retirees eligible for Medicare and
their Medicare eligible Dependents

GROUP No. 63242-05
Medicare eligible Dependents of Early Retirees

GROUP No. 63242-07
Medicare eligible Members not eligible for a pension
and Early Retirees eligible for Medicare and
their Medicare eligible Dependents

GROUP Nos. 584031, 884039 and 884040
Medicare eligible individuals enrolled in Security Blue
(Medicare HMO)

BLUE CROSS/BLUE SHIELD MEDICAL PLAN

Note: This Section of Benefits applies only
to Groups 51242-00, -02, -04, -06, and -08.

GENERAL INFORMATION

CONVERSION

If you do not wish to continue coverage through the Carpenter’s COBRA Continuation Program (see section labeled COBRA Continuation Coverage), you will be able to enroll in a Blue Cross Blue Shield Direct Payment Program. Also, conversion is available to anyone who has elected continued coverage through the Fund’s Program and the term of that coverage has expired.

If your coverage through the Fund is discontinued for any reason, except as specified below, you may convert to a direct payment program.

The conversion opportunity is not available if either of the following applies:

1. You are eligible for another group health care benefits program through your place of employment.

2. When your employer’s Program is terminated and replaced by another health care benefits program.

PROVIDERS

Providers can be hospitals, skilled nursing facilities, doctors, laboratories and other health care facilities and professionals that supply services eligible for benefit coverage under this Program.

HOW TO FILE A CLAIM

Hospital and Other Health Care Facility Claims

When you receive health care services:

- Show your identification card to the provider of service
- Ask the provider to file a claim for you

If the provider of service files a claim for you, he/she will then submit all necessary claim information to Blue Cross Blue Shield and will receive reimbursement directly.

In some cases, however, you may have to submit a claim for benefits directly to Blue Cross Blue Shield. You may have to file a claim under the following circumstances:

1. When services are provided in hospitals or other health care institutions which do not contract with Blue Cross Blue Shield.

2. When outpatient services are provided by hospitals outside of the geographic area served by your local Blue Cross Blue Shield Plan.

3. When a provider has charged you for a service that you believe should be submitted to Blue Cross Blue Shield.

4. When you believe that the provider's claim submitted to Blue Cross Blue Shield was inaccurate.

If you must submit a claim for hospital services received, you should:

- Obtain an itemized bill from the hospital
- Obtain a claim form from Blue Cross Blue Shield
- Complete the claim form and attach the itemized bill to the form
- Send the claim form and bill to the address on the claim form

Payment for eligible benefits will be made to the hospital unless your claim includes a paid receipt. If a receipt is submitted with your claim, payment will be sent to you.

Blue Cross Blue Shield will process your claim within 90 days unless special circumstances require additional processing time. If additional information is needed to process your claim, Blue Cross Blue Shield may request additional information from you or the provider. When certain expenses are not eligible under your health care program, you will be notified by Blue Cross Blue Shield that the claim is denied with an explanation of the reasons for the denial.

Doctor and Other Professional Providers' Claims

A claim for Professional Providers' services will usually be submitted by the Professional Provider to Blue Cross Blue Shield. However, in some instances (such as when the Professional Provider provides services outside of your local Plan area, or when the Professional Provider is not a Blue Cross Blue Shield participating doctor) a Professional Provider will not submit claims to Blue Cross Blue Shield. In these instances you should submit the claim to Blue Cross Blue Shield directly. Blue Cross Blue Shield will process the claim within 90 days of receipt thereof unless special circumstances require an extension of time. If more information is required to make a benefit determination, Blue Cross Blue Shield may request data from the Professional Provider or you. When benefits cannot be provided under this health care plan, you will be notified by Blue Cross Blue Shield that the claim has been denied with an explanation of the reasons for the denial.

Blue Cross Blue Shield Claim Review Procedure

Blue Cross Blue Shield have agreed to undertake the claims review responsibility required under the Employee Retirement Income Security Act of 1974 (ERISA).

If, under this Program of health care benefits, you have a claim denied, you may request, in writing, a full review of that denial to the local Blue Cross or Blue Shield Plan. The written request must be made within 60 days following receipt of a denial notice and must include the employee's name and Blue Cross Blue Shield agreement number. You, upon request to Blue Cross Blue Shield, may, at reasonable times, review documents in Blue Cross Blue Shield's possession and submit written comments pertinent to your claim. Blue Cross Blue Shield will complete a review of the claim within 60 days of receipt of the request for review unless special circumstances require an extension of time. Upon

completion of the review by Blue Cross Blue Shield, you will be advised, in writing, of the final outcome of the claim.

BLUE CARD PROGRAM

When you obtain health care services through the BlueCard Program outside the geographic area we serve, the amount you pay for covered services is usually calculated on the lower of

- The actual billed charges for your covered services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan passes on to us.

Often, this “negotiated price” will consist of a simple discount. But sometimes it is an estimated final price that factors in expected settlements or other non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be a discount from billed charges that reflects average expected savings. The Blue Cross and/or Blue Shield Plans may adjust their future estimated or average prices if the estimated or average prices used in the past were either too high or too low.

In addition, laws in a small number of states require Blue Cross and/or Blue Shield Plans to use a basis for calculating your payment for covered services that does not reflect the entire savings realized or expected to be realized on a particular claim. When you receive covered health care services in those states, your required payment for these services will be calculated using their statutory methods.

BLUE CROSS BLUE SHIELD INTERNATIONAL ASSISTANCE SERVICE

This service provides assistance with medical problems you may incur while traveling outside of the United States. Services include:

- Making referrals and appointments for you with nearby physicians or hospitals
- Verbal translation from a multilingual service representative
- Providing assistance if special medical help is needed
- Making arrangements for medical evacuation services
- Processing inpatient hospitalization benefit claim forms (for outpatient care received abroad, you should pay the provider, then file a benefits claim with Blue Cross Blue Shield when you return home).

These and other services are available 24 hours a day, every day of the year. If you’re in the U.S. and need these services, call 1-800-522-2855. If you’re abroad, call 804-673-1140 collect.

MEDICAL NECESSITY AND APPROPRIATENESS

Your coverage helps pay health care expenses that Blue Cross Blue Shield determine are medically necessary and appropriate. To be medically necessary and appropriate, your tests, treatments, services and supplies must:

- Be necessary and appropriate for the symptoms and diagnosis or treatment of your condition, illness, disease or injury.
- Be provided for the diagnosis, or the direct care and treatment of your condition, illness, disease or injury.
- Be in accordance with standards of good medical practice.
- Not be provided primarily for the convenience of your provider or you.
- Be the most appropriate supply or level of service that can safely be provided to you. When applied to hospitalization, this further means that you require acute care as a bed patient due to the nature of the services rendered or your condition, and you cannot receive safe or adequate care as an outpatient.

Blue Cross Blue Shield reserve the right to determine in its sole judgment whether a service is medically necessary and appropriate.

No benefits will be provided unless Blue Cross Blue Shield determine that the service or supply is medically necessary and appropriate.

SUBROGATION

Subrogation means that if you incur health care expenses for injuries due to an accident caused by another person, the person causing the accident is responsible for paying these expenses.

For example, if you or one of your dependents receive Blue Cross Blue Shield benefits for injuries caused by another person, Blue Cross Blue Shield has the right, through subrogation, to seek repayment from the other person or his/her insurance company for benefits already paid. Blue Cross Blue Shield Plans will provide eligible benefits when needed, but you may be asked to show documents or take other necessary actions to support Blue Cross Blue Shield Plans in its subrogation efforts.

Subrogation does not apply to an individual insurance policy you may have purchased for yourself or your dependents or if specifically prohibited by law.

COORDINATION OF BENEFITS

Coordination of Benefits becomes a factor in paying for benefits when you are insured through your Employer's health care Program and another group health care program. The purpose of Coordination of Benefits is to conserve funds allocated to health care by preventing duplicate payments.

When you receive services covered under your Employer's Program and another group health care program, a determination will be made as to which Program is "primary" and which is "secondary." If your Employer's Program is primary, benefits will be paid according to the terms of your benefit program. If your Employer's Program is secondary, any benefits paid by the primary program will be taken into account before benefit determination is made through your Employer's Program.

The determination of which Program is primary and which is secondary will be made as follows:

1. If the other group health care program does not include a Coordination of Benefits provision, the other program will be primary.

2. If the other group health care program includes a Coordination of Benefits program, the primary program will be determined in the following order:

   a. The program covering the employee (the applicant) will be considered primary.

   b. If both parents' programs cover the patient as a dependent child, the program of the parent whose birthday falls earlier in the calendar year will be primary. But, if both parents have the same birthday, the program which covered the parent longer will be primary. However, if the parents are separated or divorced, the following will apply:

1) The program which covers the child as a dependent of the parent with custody will be primary.

2) If the parent with custody has remarried, the program which covers the child as a dependent of the stepparent with custody will be primary and the program covering the child as a dependent of the parent without custody will be secondary.

3) Where there is a court decree which establishes financial responsibility for the health care expenses of the dependent child, the program which covers the child as a dependent of the parent with financial responsibility will be primary.

   c. Where the determination cannot be made in accordance with a. or b.

above, the program which has covered the patient for the longer period of time will be primary provided that:

1) The benefits of a program covering the person as an employee, other than a laid-off or retired employee, or as the dependent of such person, will be determined before the benefits of a program covering the person as a laid-off or retired employee or as a dependent of such person; and

2) If the other program does not have a provision regarding laid-off or retired employees, and, as a result, the benefits of each program are determined after the other, then c. 1) above will not apply.

3. Services provided under any governmental program for which any periodic payment of rate is made by or for you or your dependent will always be primary, except when prohibited by law, or when Medicare is elected as the secondary program.

If it is determined that your Employer's Program is secondary, Blue Cross Blue Shield have the right to recover any expenses already paid in excess of its liability as the secondary program. You may be required to furnish information and to take any action necessary to assure the rights of Blue Cross Blue Shield.

DISCLOSURE

Your health benefits are entirely funded by the Carpenters of Western Pennsylvania Medical Plan. Highmark Blue Cross Blue Shield provide administrative and claims payment services only.

MANAGED CARE PROGRAM

(Voluntary)

Health Services Operations (HSO), a division of Highmark Blue Cross Blue Shield, administers the Managed Care Program which is included with your Blue Cross and Blue Shield benefits. The aim of this program is to ensure that you receive:

- Quality care that is medically necessary; and
- Health care services in settings which best meet individual treatment needs.

PREADMISSION/ADMISSION REVIEWS

For a no-obligation case review, call HSO prior to a non-emergency inpatient admission to a:

- Hospital
- Alcohol abuse treatment facility
- Drug abuse treatment facility
- Psychiatric hospital
- Rehabilitation hospital

If you choose to initiate this service, you, your dependent, or the attending physician should contact HSO prior to the admission for determination as to whether the setting is appropriate; or whether alternative care, such as outpatient care, is more appropriate. Call HSO, using a toll-free phone number (listed on your Blue Cross/Blue Shield Identification Card); or ask your physician to call HSO. Where alternative services are more appropriate, HSO will work with you and the Attending Physician to discuss the alternatives.

It is your option to initiate a request for a Preadmission Review.

Admission Review applies to all emergency and maternity admissions to a

facility. It is recommended that HSO be notified within twenty-four (24) hours to review your admission.

It is your option to initiate a request for an Admission Review.

OTHER PROGRAM COMPONENTS

Continued Stay Review

While you or your covered dependent is in a facility, HSO will be in contact with the facility by telephone or on-site visit to make sure that continued treatment is appropriate. HSO performs its reviews of the need for continued stay by using Registered Nurses. Reviews are performed in consultation with the patient's physician to see that benefits remain in force as long as needed within your benefit limits.

If the continued stay is determined to be no longer necessary, the HSO Registered Nurse and the Attending Physician will discuss plans for a continued course of treatment in a more appropriate health care setting.

Case Management

This program component concentrates on those cases where the early identification of catastrophic and chronic cases can enhance the quality of care to be provided and enhance the recovery of the patient. When catastrophic or chronic illness strikes, there often arises a need for medical services and supplies which may not be provided by Blue Cross. Blue Cross will provide or approve any service, supply, equipment, or benefit which would otherwise not have been covered as long as:

- The condition of you or your covered dependent, in the judgment of HSO, is one that would benefit from case management intervention;
- The provision of these services, supplies, equipment, or benefits has been identified by HSO as an acceptable treatment alternative; and
- The provision of these services represents a less costly means of providing health care benefits required by the patient.

A situation that requires case management is generally identified through the Review program(s) described above, or through a referral by Blue Cross, hospital, physician or other provider. An HSO Nurse Manager will contact you or the patient if case management is appropriate.

Patient Consultation

In order to provide information to you about health service utilization, the Managed Care Program includes a Patient Consultation service. Patient Consultations are designed to help you better understand the new alternatives to inpatient stay and become a wiser consumer of health care services. HSO personnel will answer your questions concerning ambulatory care resources, efficient inpatient planning, and effective use of community resources in order to ensure that you and your covered dependents receive the highest quality health care.

Maternity Services

You and your covered dependents are encouraged to call HSO when a pregnancy has been confirmed to take advantage of services for expectant mothers, including information on prenatal care and childbirth.

NOTE:

The Managed Care Program provided by HSO is voluntary. There is no penalty for not calling HSO, however, it is recommended that you do call. It is important that you also notify HSO if there has been a change in a planned admission which has already been reviewed by HSO.

HOSPITALIZATION BENEFITS

THE BENEFITS IN THIS SECTION WILL BE COVERED ONLY WHEN AND SO LONG AS THEY ARE DETERMINED TO BE MEDICALLY NECESSARY AND APPROPRIATE FOR THE PROPER TREATMENT OF THE PATIENT'S CONDITION. PLEASE REFER TO "MEDICAL NECESSITY AND APPROPRIATENESS" IN THE GENERAL INFORMATION SECTION.

DEDUCTIBLE

When you or an enrolled dependent receive inpatient hospital care, you will be required to pay the first $200 of expenses incurred during a calendar year. You are responsible for this $200 deductible only once per family per calendar year.

PROVIDERS OF SERVICE

Hospitals and certain other health care institutions are called "Facility Providers." The following are considered Facility Providers:

Hospital
Alcoholism Treatment Facility
Ambulatory Surgical Facility
Birthing Facility
Drug Abuse Treatment Facility
Freestanding Dialysis Facility
Home Health Care Agency
Hospice
Outpatient Alcohol Abuse Treatment Facility
Outpatient Drug Abuse Treatment Facility
Outpatient Rehabilitation Facility
Skilled Nursing Facility
Psychiatric Hospital
Rehabilitation Hospital

To be eligible under the Program, the Facility Provider must be accredited or otherwise approved by Blue Cross Blue Shield.

BENEFIT PERIOD

When inpatient care is medically necessary, your basic coverage provides up to 365 days of care. This is referred to as a "benefit period." You become eligible for a new benefit period (an additional 365 days) whenever you do not use any inpatient care for at least 180 consecutive days.

In certain types of cases, the number of benefit days may differ from the amount shown above. See "Special Inpatient Limitations" for details.

INPATIENT HOSPITAL SERVICES

Bed, board and general nursing services in

- A semiprivate room
- A private room – the private room allowance is the hospital's most common charge for semiprivate rooms. If you occupy a private room, you will be required to pay the hospital the excess, if any, of its regular charge for a private room over the hospital's most common charge for semiprivate rooms. However, if the use of a private room is ordered by the attending physician because the patient's condition requires isolation, the full cost of the private room is covered.
- A special care unit which gives intensive care to the critically ill patient

Ancillary services such as:

- Operating, delivery and treatment rooms
- Prescribed drugs
- Blood processing and administration
- Anesthesia, anesthesia supplies and services
- Medical and surgical dressings, supplies, casts and splints
- Diagnostic services
- Therapy services

MATERNITY BENEFITS

Maternity benefits are available to female employees and spouses of employees. These benefits include nursery care for the newborn child.

Benefits are not provided for normal pregnancy services for dependent children.

TRANSPLANT SERVICES

Benefits are available for human organ transplant services, including removal of an organ from a donor when the donor is not covered under this Program or any other health care plan.

SPECIAL INPATIENT LIMITATIONS

Psychiatric Care

If needed, you may use a portion of the total days referred to under “Benefit Period” for the treatment of psychiatric disorders. Benefits are provided for a maximum of 120 days per admission.

INPATIENT ADMISSIONS AND OUTPATIENT VISITS

Sterilization

Benefits are available to employees and spouses of employees for sterilization and its reversal, regardless of medical necessity. Benefits are not provided for sterilization services for dependent children.

Oral Surgery

Benefits are available for the following:

- Extraction of impacted teeth
- Extraction of teeth other than impacted teeth or other dental surgical procedures provided inpatient hospitalization or outpatient care is medically necessary and appropriate to safeguard the health of the patient
- Anesthesia services, in connection with covered oral surgery services, are provided as long as they are not administered by the oral surgeon.

Benefits for Alcoholism and Drug Abuse

Inpatient Detoxification

If you are admitted for detoxification, benefits will be provided up to seven (7) days per admission. The lifetime maximum is four (4) admissions.

Inpatient Non-Hospital Rehabilitation

If you are admitted for a prescribed course of rehabilitation therapy for alcoholism or drug abuse, benefits will be provided up to 30 days per calendar year. The lifetime maximum is 90 days.

Outpatient Rehabilitation

If you are accepted as an outpatient, benefits will be provided up to 60

full session visits or equivalent partial visits per calendar year. The lifetime maximum is 120 visits. A maximum of 30 of these visits may be exchanged on a two-for-one basis to secure up to 15 additional days per calendar year for inpatient non-hospital rehabilitation services beyond the 30-day limit as referred to above. The additional exchange days are subject to the lifetime limits.

OUTPATIENT CARE

Emergency Accident Care

Benefits are available for the initial visit provided such treatment begins within 72 hours after the accident.

Hospital benefits will also be provided for emergency accident follow-up visits whether or not the emergency care was received in the outpatient department of a hospital.

Emergency Medical Care

Benefits are available for the initial visit when required for the treatment of a sudden and acute medical condition. The patient's symptoms must be so severe that absence of immediate treatment could reasonably result in permanent damage to the patient's health.

Surgery

Benefits are available for cases not classified as oral surgery.

Also covered is the orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus.

Diagnostic Services

Benefits are available for:

- Diagnostic X-ray, consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine, including mammograms.
- Diagnostic pathology, consisting of laboratory and pathology tests.
- Diagnostic medical procedures, consisting of electrocardiogram, electroencephalogram, other electronic diagnostic medical procedures, and physiological medical testing.
- Allergy testing.
- Audiometric testing.

Routine Physical Examination

Benefits are available to members and their dependents age 18 and over for routine physicals once every two (2) years, including the examination and related diagnostic tests.

Routine Gynecological Examination and Pap Test

Benefits are available to all females, regardless of age, for the following:

- One (1) routine gynecological examination, including a pelvic and clinical breast examination, per calendar year.
- Papanicolaou smear (Pap Test)

Benefits are not subject to any deductibles and/or maximums, if applicable.

Mammography Benefits

Routine mammography benefits are available to females age forty (40) and over once per calendar year. In addition, mammography benefits are available to all females, regardless of age, when recommended by their physician.

Therapy Services

Benefits are available for the following therapy services:

- Radiation therapy
- Dialysis treatment
- Physical therapy
- Speech therapy
- Occupational therapy
- Inhalation therapy

Pre-Admission Testing

Benefits are available for tests and studies required before scheduled inpatient admission for surgery.

No benefits are provided for services:

- Repeated when you are admitted as an inpatient
- If you elect to cancel or postpone the scheduled admission
- Performed to establish a diagnosis

SPECIAL FACILITIES AND SERVICES

Skilled Nursing Facility Benefits

If you require skilled nursing care, you may use any unused portion of the Benefit Period for care in a Skilled Nursing Facility. Two (2) days of care in a Skilled Nursing Facility count as one (1) inpatient hospital day.

No benefits are provided:

- After you have reached the maximum level of recovery possible, and you require only supportive care, or when skilled nursing services are not required to be provided by licensed professionals on a continuing daily basis.
- When confinement is intended solely for convenience or for custodial care.
- For treatment of alcoholism, drug abuse, or mental illness.

Home Health Care Benefits

Home Health Care benefits are limited to 100 visits per person, per 12-month period. When you are essentially homebound and require home care services, benefits will be available for the following when provided by a hospital program for Home Health Care or Home Health Care Agency.

- Skilled nursing services of an RN or LPN, excluding private duty nursing services
- Physical therapy
- Medical and surgical supplies
- Oxygen and its administration
- Medical social services
- Home health aide services when you are also receiving covered nursing or therapy services.

No benefits are provided for:

- Dietitian services
- Homemaker services
- Maintenance therapy
- Dialysis treatment or equipment
- Meals
- Drugs and medications.

Hospice Care Benefits

Benefits are available for the following services provided by a Hospice Care Program for care of a terminally ill patient with a life expectancy of six (6) months or less. The services must be provided according to a physician-prescribed treatment plan.

- Professional nursing services of an RN or LPN
- Home health aide services
- Medical care rendered by a Hospice Care Program physician
- Therapy services except dialysis treatment
- Diagnostic services
- Medical and surgical supplies and durable medical equipment
- Prescription drugs
- Oxygen and its administration
- Medical social services
- Respite care
- Family counseling related to the patient's terminal condition
- Dietitian services
- Inpatient room, board and general nursing service

No benefits are provided for:

- Medical care rendered by the patient's private physician
- Volunteer services
- Pastoral services
- Homemaker services
- Food or home delivered meals
- Private duty nursing services

Chemotherapy Treatment

Benefits are available for chemotherapy for treatment of malignant diseases regardless of the type of facility in which treatment is rendered.

Pediatric Immunizations

Benefits will be provided for those pediatric immunizations, including the immunizing agents, which, as determined by the Pennsylvania Department of Health, conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control, U.S. Department of Health and Human Services. Benefits are limited to dependent children and are not subject to any deductibles and/or maximums.

BENEFITS AFTER TERMINATION OF COVERAGE

If you are an inpatient on the day your coverage under this Program terminates, benefits of this Program will continue until the earliest of the following:

- Maximum benefits have been received
- The inpatient stay ends
- You become covered for the condition for which you are receiving inpatient care under any other group coverage.

MEDICAL-SURGICAL BENEFITS

THE BENEFITS IN THIS SECTION WILL BE COVERED ONLY WHEN AND SO LONG AS THEY ARE DETERMINED TO BE MEDICALLY NECESSARY AND APPROPRIATE FOR THE PROPER TREATMENT OF THE PATIENT'S CONDITION. PLEASE REFER TO "MEDICAL NECESSITY AND APPROPRIATENESS" IN THE GENERAL INFORMATION SECTION.

PROVIDERS OF SERVICE

Doctors and certain other health care professionals are called "Professional Providers." The following are considered Professional Providers:

- Certified Clinical Nurse Specialist*
- Certified Community Health Nurse*
- Certified Enterostomal Therapy Nurse*
- Certified Psychiatric Mental Health Nurse*
- Certified Registered Nurse Anesthetist*
- Certified Registered Nurse Practitioner*

*Excluded from eligibility are registered professional nurses employed by a health care facility or by an anesthesiology group.

- Chiropractor
- Clinical Laboratory
- Dentist
- Doctor of Medicine
- Nurse Midwife
- Optometrist
- Osteopath
- Physical Therapist
- Podiatrist
- Psychologist

To be eligible under the Program, the Professional Provider must be licensed, where required, and be performing services within the scope of such license.

PAYMENT OF BENEFITS

Usual, Customary and Reasonable (UCR) Method

Blue Cross Blue Shield reimbursement amounts are often referred to as UCR allowances. UCR is an abbreviation for usual, customary and reasonable. It is a method used to determine and pay providers on the basis of:

The Usual Fee — The fee an individual Professional Provider most frequently charges the majority of patients for the procedure performed.

The Customary Fee — The fee based on charges made by most Professional Providers of the same specialty in comparable geographical/economic areas for the procedure performed.

The Reasonable Fee — The fee, which may differ from the usual or customary charge, determined by considering unusual clinical circumstances; the degree of professional involvement; or the actual cost of equipment and facilities involved in providing the service.

Payment for covered services performed by Highmark Blue Cross Blue Shield Participating Professional Providers will be made to the provider on the basis of 100% of the UCR allowance or the amount charged, whichever is less.

A Participating Professional Provider must accept the allowance as payment-in-full for covered services. You will be responsible for any deductibles and amounts exceeding the maximum (if applicable under the program) or any service not covered by Blue Cross Blue Shield. The sum of your payment and the Blue Cross Blue Shield payment will be accepted as payment in full provided that your payment is made to the Participating Professional Provider within 60 days of notification by Blue Cross Blue Shield. If your payment is

not made within 60 days the Participating Professional Provider may bill you the difference between the charge and the UCR allowance.

Payment for covered services performed by non-participating Professional Providers will be made to you on the basis of 80% of charges or 100% of the UCR allowance, whichever is less. Such payment will constitute full discharge of Blue Cross Blue Shield's liability under the Program. Nonparticipating Professional Providers are not obligated to accept the UCR allowance as payment-in-full. You will be responsible for payment of the remaining charges.

SERVICE BENEFITS

If you had services performed by Highmark Blue Cross Blue Shield Participating Professional Provider, and the Provider bills you for expenses other than the deductible, coinsurance, amounts exceeding the maximum or ineligible services (if applicable under the Program), do the following:

Discuss the situation with the Provider.

If you do not come to a mutually satisfactory settlement of the disagreement, then:

1. Contact Highmark Blue Cross Blue Shield in writing at:
   P.O. Box 898847
   Camp Hill, PA 17089-8847.
2. Advise Blue Cross Blue Shield of the situation.

Blue Cross Blue Shield will review the situation to resolve the disagreement. The decision by Blue Cross Blue Shield will be final.

SURGERY

Benefits are provided for surgical services for the treatment of disease or injury. A separate payment will not be made for inpatient pre-operative care or any post-operative care which is normally provided by the surgeon as part of the surgical procedure.

Benefits are also provided for sterilization procedures and procedures to reverse sterilization, regardless of medical necessity.

Also covered is the orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus.

If more than one surgical procedure is performed by the same Professional Provider during the same operative session, Blue Cross Blue Shield will pay 100% of the UCR allowance for the highest paying procedure and no allowance for additional procedures except where Blue Cross Blue Shield deems that an additional allowance is warranted. A Participating Provider is under contract not to charge separately for the lesser cost procedure.

ORAL SURGERY

Benefits are provided for the surgical removal of impacted teeth which are partially or totally covered by bone, apicoectomies, alveolectomies and soft tissue impactions. Also covered is treatment for accidental injuries to natural teeth, including x-rays, when such treatment is performed within twelve (12) months of the date of the initial accident.

TRANSPLANT SERVICES

Benefits are provided for human organ transplant services, including the covered services for the removal of an organ from a donor when the donor is not covered under this Program or any other health care plan.

ASSISTANT AT SURGERY

Benefits are provided for services of an assistant surgeon who actively assists the operating surgeon when Blue Cross Blue Shield determines that the condition of the patient or the type of surgical service requires such assistance, limited to inpatient services only.

Surgical assistance is not covered when performed by a Professional Provider who performs and bills for another surgical procedure during the same operative session. A Participating Provider is under contract not to charge separately for the lesser cost procedure.

ANESTHESIA

Benefits are provided for the administration of anesthesia in connection with covered services. The anesthesia must be administered by or under the direct supervision of a Professional Provider other than the surgeon or assistant surgeon.

When anesthesia services are administered by a nurse anesthetist, not employed by a Professional Provider, payment will be made at 50% of the usual allowance.

Administration of local infiltration anesthetic is not covered.

OUTPATIENT SECOND SURGICAL OPINION CONSULTATION FOR SURGERY

Benefits will be provided for a second opinion consultation to determine the medical necessity of an elective surgical procedure. Elective Surgery is surgery which is not of an emergency or life threatening nature.

Such services must be performed and billed by a Professional Provider other than the one who initially recommended performing the surgery. One additional consultation, as a third opinion, is eligible in cases where the second opinion disagrees with the first recommendation. In such instances, you will be eligible for a maximum of two (2) such out-of-hospital consultations involving the elective surgical procedure in question, but limited to one (1) consultation per consultant.

INPATIENT MEDICAL CARE

Benefits are provided for medical services by the Professional Provider in charge of the case when you are an inpatient in the hospital, rehabilitation hospital, or skilled nursing facility for a condition not related to surgery, maternity services, radiation therapy, or psychiatric care. These services are available for a total of 365 days for each period of hospitalization. At least 180 consecutive days must elapse between discharge from and subsequent admission to a hospital or skilled nursing facility before inpatient stays will be considered a new period of hospitalization.

Inpatient medical care also includes observation care and intensive medical care rendered to a patient whose condition requires a Professional Provider’s constant attendance for a prolonged period of time.

CONCURRENT CARE

Benefits are provided for inpatient medical care by a Professional Provider who is not in charge of the case, but whose particular skills are required for the treatment of complicated conditions. This does not include reassurance of the patient, standby services, routine pre-operative physical examinations, or medical care routinely performed in the pre- or post-operative or pre- or post-partum periods.

CONSULTATION

Benefits are provided for consultations when rendered to an inpatient by a

Professional Provider if the patient's condition requires it, and the Professional Provider in charge of the case requests the consultation. You are limited to one (1) consultation per consultant during any one (1) inpatient stay. In addition, physician consultation services performed in the Outpatient Hospital Facility Setting will be covered if the patient's condition requires it and the Professional Provider in charge of the case requests the consultation.

EMERGENCY ACCIDENT CARE

Benefits are provided for medical care for the initial treatment of traumatic bodily injuries resulting from a non-occupational accident.

Emergency accident care must begin within 72 hours of the accident.

Benefits are also provided for follow-up care within 60 days of the accident.

Benefits will not be provided if any other benefit of this Program is payable. For example: If the accident services are classified as surgery (suturing, fracture care, etc.) payment will be made as a surgical benefit.

EMERGENCY MEDICAL CARE

Benefits are provided for the initial treatment of a sudden onset of a medical condition with acute symptoms of sufficient severity to require immediate medical attention.

DIAGNOSTIC SERVICES

Benefits are provided for the following diagnostic services required to determine a definite condition or disease:

- Diagnostic X-ray services consisting of radiology, ultrasound, and nuclear medicine, including mammograms.
- Diagnostic laboratory and pathology tests ordered and billed by a Professional Provider.
- Diagnostic medical procedures consisting of electrocardiograms, electroencephalograms, and other diagnostic medical procedures approved by Blue Cross Blue Shield.
- Allergy testing performed and billed by a Professional Provider. The allergy extract or office visit in connection with the testing is not covered.

ROUTINE PHYSICAL EXAMINATION

(For Groups 51242-00 and 51242-02 only)

Benefits are available to members and their dependents age 18 and over for routine physicals once every two (2) years, including the examination and related diagnostic tests. See Pediatric Preventative Care Benefit for children age 17 and under.

PEDIATRIC PREVENTATIVE CARE BENEFIT

(For Groups 51242-00 and 51242-02 only)

Benefits are provided for all children, newborn through age 17.

Preventive services are covered when performed and billed for by a Professional Provider. Benefits are provided for the following services when the service is received during the ages listed below.

"Preventive Services," generally, describes health care services performed to catch the early-warning signs of health problems. These services are performed when you have no symptoms of an illness or evidence of disease. Services performed to treat an illness or disease are not covered under the

Preventive Services program. Please note that office visit charges for children because of illness will continue to be covered through the Fund Office after a $100 per person per year deductible.

Routine History and Physical Examination and Urinalysis

Generally included is a medical history, height and weight measurement, physical examination, and counseling. Pediatric Preventive Services covers 24 exams up to age 17 – one exam during each of the following age groupings:

1. Newborn
2. 2 to 4 days old
3. 0-1 months
4. 2 months
5. 4 months
6. 6 months
7. 9 months
8. 12 months
9. 15 months
10. 18 months
11. 24 months
12. 3 years
13. 4 years
14. 5 years
15. 6 years
16. 8 years
17. 10 years
18. 11 years
19. 12 years
20. 13 years
21. 14 years
22. 15 years
23. 16 years
24. 17 years

The member would be responsible for a $10 office visit copay. Blue Cross Blue Shield periodically reviews the schedule of covered services based on recommendations from organizations such as The American Academy of Pediatrics, The American College of Physicians, the U.S. Preventive Services Task Force, The American Cancer Society, and The Blue Cross and Blue Shield Association. Accordingly, the frequency and eligibility of services is subject to change.

ROUTINE GYNECOLOGICAL EXAMINATION AND PAP TEST

Benefits are provided to all females, regardless of age, for one (1) routine gynecological examination annually and Pap Test, as required. The gynecological examination may include, but is not limited to, the following services: office visit, history, blood pressure and/or weight checks, physical examination of pelvis/genitalia, rectum, thyroid, breasts, axillae, abdomen, lymph nodes, heart and lungs. The Pap Test is the leading screening test for cervical cancer.

Benefits are not subject to any deductibles and/or maximums, if applicable.

MAMMOGRAPHY BENEFITS

Routine mammography benefits are available to females age forty (40) and over once per calendar year. In addition, mammography benefits are available to all females, regardless of age, when recommended by their physician.

THERAPY SERVICES

Benefits are provided for the following therapy services:

- Radiation therapy, including the cost of radioactive materials;
- Chemotherapy;
- Dialysis treatment;
- Physical therapy;
- Respiration therapy.

MATERNITY CARE

Benefits are provided to female employees and spouses of employees for maternity care, including pre-partum and post-partum care, performed by a

Professional Provider.

Benefits are not provided for normal pregnancy services for dependent children.

NEWBORN CARE

Benefits are provided for visits by a Professional Provider to examine the newborn while the mother is confined in a hospital or birthing center.

PSYCHIATRIC CARE

If needed, you may use a portion of the total days referred to under "Inpatient Medical Care" for the treatment of psychiatric disorders. Benefits are provided up to a maximum of 120 days per admission.

Benefits are also provided for shock therapy services, including anesthesia, when performed and billed for by a Professional Provider.

These benefits are also available for the treatment of drug abuse and alcoholism.

SKILLED NURSING FACILITY CARE

Benefits are available for medical care in a skilled nursing facility if:

- Your illness or injury requires at least three (3) days of hospitalization;
- Your condition requires skilled nursing care for continued treatment; and
- You are admitted to the skilled nursing facility within 14 days following discharge from an accredited hospital

Skilled nursing care is limited to two (2) visits during the first week of confinement and one (1) visit a week for each consecutive week of confinement thereafter. Each day of skilled nursing facility medical care counts as one-half ($^1/_2$) day against the total days available for inpatient medical services.

PEDIATRIC IMMUNIZATIONS

Benefits are provided for those pediatric immunizations, including the immunizing agents, which, as determined by the Pennsylvania Department of Health, conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control, U.S. Department of Health and Human Services. Benefits are limited to dependent children and are not subject to any deductibles and/or maximums.

INJECTIONS

Benefits are available for the administration of injections into the muscles such as, but not limited to, allergy injections, vitamin B-12 injections, therapeutic injections to offset nausea from chemotherapy.

BENEFITS AFTER TERMINATION OF COVERAGE

If you receive services after the date of termination no benefits will be paid.

WHAT IS NOT COVERED

You are not covered for Hospital or Medical-Surgical services, supplies or charges:

- Which are not medically necessary or medically appropriate as determined

by the Plan;

- Which are experimental/investigative in nature;
- Which are not prescribed, performed or billed by a Professional Provider;
- Rendered by a provider not specifically listed in this booklet;
- For any illness or injury eligible for or covered by any federal, state or local government Workers' Compensation Act or Occupational Disease Law;
- To the extent benefits are provided to members of the armed forces and the National Health Service or to patients in Veteran's Administration facilities for service-connected illness or injury unless the Subscriber has a legal obligation to pay;
- For any illness or injury suffered after your effective date as a result of any act of war;
- For which you have no legal obligation to pay;
- Received from a dental or medical department maintained in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or any similar person or group;
- For personal hygiene and convenience items such as, but not limited to: air conditioners, humidifiers, physical fitness equipment, stair glides, elevators/lifts or "barrier free" home modifications, whether or not recommended by a Professional Provider, or Other Professional Provider;
- For correction of myopia or hyperopia by means of corneal microsurgery, such as keratomeleusis, keratophakia, and radial keratotomy and all related services;
- For telephone consultations, charges for failure to keep a scheduled visit or appointment, or charges for completion of a claim form;
- For custodial care, domiciliary care or rest cures;
- For eyeglasses or contact lenses and the examination for prescribing and fitting them (except when required following a cataract operation);
- For palliative or cosmetic foot care, including flat foot conditions, supportive devices for the foot, the treatment of subluxations of the foot, care of corns, bunions (except by capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet;
- For hearing aids, tinnitus maskers, and examinations for the prescription or fitting of hearing aids;
- For inpatient admissions primarily for physical therapy;
- For any treatment in connection with transsexual surgery;
- For sexual dysfunction not related to organic disease;
- For which payment has been made under Medicare or would have been made if the Subscriber had applied for Medicare and claimed Medicare benefits;
- For which payment has been made by Medicare when Medicare is primary for reasons other than your election;
- For treatment of temporomandibular joint syndrome with intra-oral prosthetic devices, any other method to alter vertical dimensions and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma;
- For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law including any medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act;
- For any other medical or dental service or treatment except as provided in this booklet.

In addition, your hospital coverage will not provide benefits for services, supplies or charges that are for:

- Operations for cosmetic purposes except those performed to correct a condition resulting from accidental injury which occurs while you are covered by a Blue Cross Blue Shield plan or program. You must be enrolled without interruption from the date of the accident to the date of the operation in order to be eligible for cosmetic surgery related to the accidental injury;
- Outpatient eye refractions;
- Outpatient psychiatric examinations and outpatient psychological testing;
- Services rendered prior to your effective date or during an inpatient admission that commenced prior to your effective date; except covered services will be provided for an eligible condition that commenced after your effective date;
- Nutritional counseling and services intended to produce weight loss;
- Dietary or food supplements;
- Preventive care services, wellness services or programs;
- Routine or periodic physical examinations or screening examinations, except as provided herein;
- Well-baby care and immunizations, except as provided herein;
- Artificial insemination;
- In-vitro fertilization;
- Inpatient admissions primarily for diagnostic study;
- Whole blood, blood components and blood derivatives which are not classified as drugs;
- Detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.

In addition, your medical-surgical coverage will not provide benefits for services, supplies or charges that are:

- For services directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, root canal treatments and treatment of periodontal disease, except treatment for congenital cleft palates, other than what is covered herein (For information on accidental injuries to natural teeth, please see Medical-Surgical Benefits for Oral Surgery);
- Performed on high cost technological equipment as defined by Blue Cross Blue Shield, unless the acquisition of such equipment by a Professional Provider was approved through the Certificate of Need (CON) process and/or by Blue Cross Blue Shield;
- For treatment of obesity, except for surgical treatment of morbid obesity when weight is at least twice the ideal weight specified for frame, age, height and sex;
- For outpatient pre-operative care and post-operative care other than that which is normally provided following surgery;
- Operations for cosmetic purposes except those performed to correct a condition resulting from accidental injury which occurs while you are covered by a Blue Cross Blue Shield plan or program. You must be enrolled without interruption from the date of the accident to the date of the operation in order to be eligible for cosmetic surgery related to the accidental injury;
- Performed in a facility by a Professional Provider who in any case is compensated by the facility for similar services performed for patients;
- For detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column;

- Submitted by a Certified Registered Nurse and another Professional Provider for the same services performed on the same date for the same patient;
- Billed for by hospitals or other facilities;
- For services performed prior to your effective date of coverage or during an inpatient admission that commenced prior to your effective date;
- For routine or periodic physical examinations or screening examinations, except as provided herein;
- For well-baby care and immunizations, except as provided herein;
- For assisted fertilization techniques such as, but not limited to, artificial insemination, in-vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT);
- Performed by a Professional Provider enrolled in an education or training program when such services are related to the education or training;
- For clinical pathology services for which a hospital or other facility bills;
- For antigens;
- Speech or occupational therapy services.

BLUE CROSS / BLUE SHIELD MEDICAL PLAN

FOR GROUPS 63242-01, -03, -05, AND -07 AND GROUPS 584031, 884039 AND 884040

CHOICE OF PLANS

The Carpenters of Western Pennsylvania Medical Plan currently offers two (2) plans to certain Medicare eligible individuals—Medicare Supplemental Standard Plan C or Security Blue. There is no difference in the required payment for Medicare Supplemental Standard Plan C or Security Blue.

Security Blue is a Highmark Blue Cross Blue Shield Medicare HMO and is currently available only in the following counties:

Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Crawford, Erie, Fayette, Greene, Indiana, Lawrence, Mercer, Somerset, Washington and Westmoreland.

The biggest benefit of Security Blue is that it provides coverage for prescription drugs while Medicare and Standard Plan C do not. Note, however, that the Security Blue HMO requires an individual to select a primary care physician (PCP) from the network of doctors and that PCP will coordinate all care for the individual.

The Sections that follow outline the benefits provided by Standard Plan C and Security Blue. Please note that the Carpenters' Security Blue Program includes everything in the regular Blue Cross Security Blue Program plus these additional benefits:

- Unlimited prescription coverage;
- Reimbursement through the Fund Office for the $10.00, $15.00 or $35.00 office visit/emergency room copayment
- Reimbursement through the Fund Office for the $10.00 or $20.00 prescription copayment.

Please review the Sections that follow to determine if the Carpenters' Security Blue Medicare HMO option is the right option for you. Should you not select the Security Blue option, your coverage through our office will be the Medicare Supplemental Standard Plan C. Should an individual elect Security Blue

and then decide it is not appropriate for him, he will be allowed to shift back to the coverage of the Medicare Supplemental Standard Plan C offered by the Carpenters but only once and only within one year of selecting Security Blue.

Should you be interested in enrolling for the Carpenters' Security Blue Program, please contact the Fund Office to obtain an application.

BLUE CROSS/BLUE SHIELD MEDICAL PLAN

Note: This Section of Benefits applies only to Groups 63242-01, -03, -05, and -07.

Also note that anyone eligible for Medicare must be enrolled in Medicare Parts A and B, or benefits will NOT be paid.

BENEFITS PROVIDED BY BLUE CROSS BLUE SHIELD MEDICARE SUPPLEMENTAL

Standard Plan C

Hospital and Related Benefits

COVERED BENEFITS

The Blue Cross Blue Shield Medicare Supplemental Standard Plan C Program complements the Federal Government's Medicare program by providing the following benefits:

- Pays the first $768* in a Benefit Period. This deductible amount for the initial inpatient hospitalization in a Benefit Period is not covered by Medicare. (You begin a new Benefit Period under Medicare Part A each time you are admitted to a Hospital as an inpatient AND have NOT been an inpatient in a Hospital or Skilled Nursing Facility during the 60 consecutive days immediately preceding the admission.)
- Pays the $192 per day* Medicare Part A coinsurance amount during your 61st through 90th days of inpatient hospitalization.
- Pays the $384 per day* Medicare Part A coinsurance amount for your 60 Medicare lifetime reserve Hospital days. These 60 lifetime reserve Hospital inpatient days are applied:
  - after you have exhausted all of your 90 regular Medicare inpatient Hospital days in a Benefit Period, and
  - before you use any of your 365 Hospital inpatient days described below.

*These deductible and coinsurance amounts are those currently in effect during 1999.

- Medically Necessary Emergency Care in a Foreign Country. Coverage will be provided to the extent not covered by Medicare for 80% of the billed charges for Medicare Eligible Expenses for Medically Necessary and Appropriate emergency Hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, "Emergency Care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.
- Adds 365 days of Hospital care in semiprivate accommodations in your

lifetime after all applicable Medicare inpatient Hospital days have been used.

• Provides Skilled Nursing Facility benefits. Your Medicare Supplemental Agreement pays the $96* per day Medicare Part A coinsurance amount for the 21st through 100th days of care in a Skilled Nursing Facility.

Also, in lieu of the 365 additional days of inpatient Hospital care previously mentioned, Highmark Blue Cross Blue Shield will provide, on a one-for-one basis, up to 365 additional days of coverage in a Skilled Nursing Facility. This alternate benefit is available, upon medical need, after you have used the 100 days of post-hospital inpatient care in a Skilled Nursing Facility provided by Medicare Part A.

• Covers mental or nervous disorder treatment for up to 40 days in your lifetime when received as an inpatient in a Hospital or Skilled Nursing Facility and not covered by Medicare. This benefit is applicable only as part of and not in addition to your 365 additional lifetime days of Hospital and/or Skilled Nursing Facility care previously described.

• Covers blood and blood plasma expenses for the first three (3) pints received during a calendar year to the extent that the blood is not donated or otherwise replaced.

• Adds certain dental care benefits not provided by Medicare. These include hospitalization for treatment of fractures and dislocations of the jaw and extraction of impacted teeth. (Extraction of nonimpacted teeth is covered only if admission as an inpatient is necessary to safeguard your health from the effects of dentistry because of a specific non-dental organic impairment.)

• Outpatient Hospital Benefits: If you are enrolled under Medicare Part B, Highmark Blue Cross Blue Shield will cover the Medicare deductible and the 20 percent coinsurance amount for approved Hospital outpatient services. If you are NOT enrolled under Medicare Part B, Highmark Blue Cross Blue Shield will cover an amount equal to the Medicare deductible and coinsurance amount which would have been paid if you were enrolled under Medicare Part B.

FULL BENEFITS ASSURED FOR ADDITIONAL DAYS

Blue Cross Blue Shield subscribers have always had service benefit protection. This means coverage for all of the usual and customary services furnished to a Medicare Supplemental subscriber as an inpatient by a Participating Hospital for the diagnosis and treatment of a condition of illness or injury. Such services are available regardless of cost during the time that the subscriber is eligible for benefits to the extent that such services are not covered by Medicare Part A because of exhaustion of all Medicare benefit days.

These benefits include: meals and special diets; general nursing care; drugs and medicines; use of operating, recovery, and other specialty service rooms; anesthesia; laboratory examinations; X-ray examinations; dressings; plaster casts and splints; oxygen; processing and administration of blood and blood plasma; physiotherapy and hydrotherapy; radiation therapy; cardiographic examinations; electroencephalograms; basal metabolism testing; intravenous fluids and prosthetic devices surgically implanted.

If a Blue Cross Blue Shield Medicare Supplemental subscriber receives inpatient care outside Western Pennsylvania in a reciprocating Participating Hospital of another Blue Cross Plan, benefits will be provided under the terms of the contract this Plan has with the other Blue Cross Plan providing such benefits. If the inpatient care is received in a non-participating hospital, an amount per day shall be paid by Highmark Blue Cross Blue Shield against charges made by the hospital for the allowed inpatient services. This amount shall at all times be subject to the determination of Highmark Blue Cross Blue Shield. Days allowed in this manner will count as part of the 365 days of full benefits allowed under this Agreement.

SUBROGATION

Subrogation seeks to conserve subscriber funds by imposing the expense for accidental injuries suffered by subscribers on those responsible for causing them. If you, for example, should receive Blue Cross Blue Shield benefits for injuries caused by someone else, Highmark Blue Cross Blue Shield through subrogation, has the right to seek repayment from the other party or his insurance company. Highmark Blue Cross Blue Shield will provide benefits at the time of need, but the subscriber may be asked to execute and deliver such documents or take such other action as is necessary to assure the rights of Highmark Blue Cross Blue Shield. However, subrogation specifically does not apply to an insurance policy issued to and in the name of the subscriber.

COORDINATION OF BENEFITS

The Coordination of Benefits provision is applicable only to subscribers who

- are insured through another group health care plan in addition to this Program; or
- are covered under any governmental program for which any periodic payment of rate is made by or for the subscriber.

This Coordination of Benefits provision does not apply to nongovernmental individual, non-group or group conversion policies issued directly to you or one of your dependents.

If you receive services which are coverable under this Program or another group health care plan, a determination will be made as to which plan is "primary" and which is "secondary." The primary plan will pay its benefits without regard to the secondary plan. The secondary plan will then pay for any covered services which have not been paid for by the primary plan.

CERTIFICATION OF NEED

Highmark Blue Cross Blue Shield may require that the attending physician submit on behalf of the Subscriber a certificate of medical necessity stating the need for continued care. This certificate of necessity may not be requested by Highmark Blue Cross Blue Shield more often than once in a 14-day interval.

EXCLUSIONS

Medicare Supplemental does not cover:

- Injuries or diseases for which benefits are furnished or required to be furnished by an employer under any national, state, or local laws (such as Workers' Compensation), or by any government body or agency or under the Medicare program;
- Convalescent, custodial, or rest care;
- Ambulance service;
- Personal comfort or convenience items;
- Inpatient hospitalization principally for diagnosis, diagnostic study, or medical observation when the necessary care can properly be provided on an outpatient basis;
- Services and supplies which are experimental in nature;
- Services which are not medically appropriate;
- Services not reasonable and necessary for the diagnosis or treatment of an illness or injury;
- Private duty nursing services;
- Purchase or rental of durable medical equipment;
- Outpatient benefits, except as provided herein;
- Cosmetic surgery, except when related to accidental injury which occurred after your effective date;
- Treatment or services for injuries resulting from the maintenance or use

of a motor vehicle if such treatment or services are paid or payable under any applicable motor vehicle insurance policy or program, including a certified or qualified plan of self-insurance or any catastrophic loss fund established by law;

- Services in rest homes, health resorts, places primarily for domiciliary or custodial care, or in an institution not meeting this Corporation's definition of "Hospital";
- Dental care, except as provided herein.
- Skilled Nursing Facility care except as provided herein.

BENEFITS PROVIDED BY BLUE CROSS BLUE SHIELD MEDICARE SUPPLEMENTAL

Standard Plan C

Medical Surgical Benefits

COVERED BENEFITS

You are required under Part B of Medicare to pay the first $100 of your total Medicare-covered medical bills in a calendar year. Medicare then pays 80% of the balance of reasonable medically necessary charges, and you are liable for the remaining 20%.

The Blue Shield Medicare Supplemental Standard Plan C, however, is designed to pay the $100 deductible and the 20% coinsurance for you.

Following is a partial list of services and supplies for which Blue Shield Medicare Supplemental will pay the 20% not paid by Medicare:

- the fee for medical services when you visit your provider in his office, or when he calls upon you in your home or in the hospital;
- the surgeon's charge when you have an operation;
- the consulting provider's fee when his service is required;
- Medically Necessary Emergency Care in a Foreign Country. Coverage will be provided to the extent not covered by Medicare for 80% of the billed charges for Medicare Eligible Expenses for Medically Necessary and Appropriate emergency Hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, "Emergency Care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.
- the rental or purchase of durable medical equipment for use in your home, when prescribed by a provider;
- the charges for X-ray, radium, and radioactive isotope therapy;
- the charges for splints, casts, and surgical dressings;
- the charges for diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests;
- the charges for prosthetic devices (except dental) which replace all or part of an internal body organ, unless covered under Medicare Part A;
- the charge for ambulance services where transportation by other means could endanger the patient's health, but only to the extent provided in the Medicare Part B regulations;
- the charges for outpatient prescription drugs used for immunosuppressive

therapy during the first year following a covered transplant;

- the charges for screening mammography, subject to the following limitations:
  - No payment may be made under this agreement if performed for a woman under 35.
  - Only one screening for women age 35-39.
  - Once every 12 months for women age 40-49 who are at high risk of developing breast cancer.
  - Once every 24 months for women age 40-49 who are not at high risk of developing breast cancer.
  - Once every 12 months for women age 50-64.
  - Once every 24 months for women age 65 and older.

THOSE ELIGIBLE TO PROVIDE SERVICES

Services and supplies can be provided by a doctor of medicine, doctor of osteopathy, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry, doctor of chiropractic, psychologist, nurse midwife or Certified Registered Nurse acting within the authority of such license.

PROVIDERS WHO ACCEPT ASSIGNMENT

Under the terms of Assignment, the Subscriber transfers to the Provider the right to both the Medicare Part B and Blue Cross Blue Shield payment based on covered services specified on the claim. The Provider, in turn, agrees to accept the reasonable charge set by the Medicare Part B carrier as his total charge for covered service.

The sum of the reasonable charge payments, 80% by Medicare Part B and 20% by Blue Cross Blue Shield, constitute payment in full, except where maximums or deductibles are specified.

The Plan reserves the right to make payment directly to the Provider.

PROVIDERS WHO DO NOT ACCEPT ASSIGNMENT

If the Provider does not accept Assignment, any difference between the Provider’s charge and the combined Medicare Part B/Blue Cross Blue Shield payment shall be the personal responsibility of the Subscriber.

Please note, however, that currently, Pennsylvania law requires Providers to accept assignment for services provided in Pennsylvania. Therefore, for covered services provided in Pennsylvania, there will be no balance billing.

The Plan reserves the right to make payment directly to the Subscriber.

NOTICE OF CLAIM

If the services were performed outside Pennsylvania, mail your Medicare Part B claim to the Medicare Part B carrier which processes claims for the area where the services were provided. The Medicare Part B carrier will automatically submit your claim to Highmark Blue Cross Blue Shield Medicare Supplemental for assigned claims. For non-assigned claims you will receive an Explanation of Medicare benefits that states your Medicare Part B claim has been paid. Notify Highmark Blue Cross Blue Shield within one (1) year after the Medicare Part B claim was finalized by mailing a copy of the Explanation of Medicare Benefits to:

Highmark Blue Cross Blue Shield Medicare Supplemental
Highmark Blue Cross Blue Shield
P.O. Box 898845
Camp Hill, Pennsylvania 17089-8845

It is your responsibility to have this Explanation of Medicare Benefits submitted within one (1) year.

SUBROGATION

Subrogation seeks to conserve subscriber funds by imposing the expense for accidental injuries suffered by subscribers on those responsible for causing them. If you, for example, should receive Blue Cross Blue Shield benefits for injuries caused by someone else, Highmark Blue Cross Blue Shield, through subrogation, has the right to seek repayment from the other party or his insurance company.

Highmark Blue Cross Blue Shield will provide benefits at the time of need, but the subscriber may be asked to execute and deliver such documents or take such other action as is necessary to assure the rights of Highmark Blue Cross Blue Shield.

However, subrogation specifically does not apply to an individual insurance policy issued to and in the name of the subscriber.

COORDINATION OF BENEFITS

Coordination of benefits is applicable only to persons who are insured through another group benefit plan or under any governmental program which any periodic payment of rate is made by or for the subscriber in addition to this Program. Its purpose is to conserve funds allocated for health care by preventing individuals from receiving more in benefits than the actual cost of such care.

When the services provided are coverable under either this Program or another group plan, a determination will be made as to which plan is "primary" and which is "secondary." The primary plan will pay its benefits without regard to the secondary plan. The secondary plan will then pay for any covered services which have not been paid for by the primary plan.

The primary plan will be determined in the following order:

- If the other plan does not include a Coordination of Benefits provision, such plan will be the primary plan.
- If the other plan does include a Coordination of Benefits provision:
  - The plan covering the patient other than as a dependent will be considered the primary plan, or
  - Where the determination cannot be made in accordance with the above, the plan which has covered the patient for the longer period of time will be considered the primary plan.
- Services provided under any governmental program for which any periodic payment of rate is made by or for the subscriber shall always be the primary plan, except when prohibited by law, or when the Subscriber has elected Medicare secondary.

Highmark Blue Cross Blue Shield may pay their benefits first and determine liability later. If it is determined that this Program is the secondary plan, Highmark Blue Cross Blue Shield has the right to recover the expense already paid in excess of their liability as the secondary plan. You may be required to furnish information and to take such other action as is necessary to assure the rights of Highmark Blue Cross Blue Shield.

EXCLUSIONS

In general, the following services, supplies or charges are not covered under Medicare Part B and, therefore, to the extent they are not covered under Medicare Part B, are not covered under the Blue Cross Blue Shield Medicare Supplemental:

- Routine physical examinations;
- Eye examinations, refractions, eyeglasses, hearing examinations or

hearing aids;

- Dental services such as the care, filling, removal or replacement of teeth, root canal therapy, surgery for impacted teeth; and other surgical procedures involving the teeth or structures directly supporting teeth;
- Routine foot care, including hygienic care, treatment of flat feet, removal of corns, warts, and calluses; partial dislocations of the joints of the feet; orthopedic shoes or other supportive devices for the feet, except those which are part of leg braces;
- Immunization (unless directly related to immediate risk of infection from injury);
- Drugs the Subscriber can administer (such as insulin), and any outpatient drugs, except drugs used in immunosuppressive therapy;
- Services and supplies that are not reasonable or necessary for diagnosis and treatment;
- Medical expenses for which the Subscriber is not legally obligated to pay;
- Hospital Services which are provided under Medicare Part A;
- Identical services performed on the same date for the same patient for which both a Certified Registered Nurse and another Provider submit a claim;
- Services performed prior to the Subscriber's Effective Date;
- For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any legislation of any governmental unit. This exclusion applies whether or not the Subscriber claims the benefits or compensation;
- Benefits, to the extent they are provided by any governmental unit; unless required by law;
- Services for which the Subscriber incurs no charge;
- Services received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;
- Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid under a plan or policy or motor vehicle insurance, including a certified self-insured plan, or payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Law;
- Any services other than those specifically provided in this Section.

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

Name and Address of Plan.

CARPENTERS' OF WESTERN PENNSYLVANIA MEDICAL PLAN

495 Mansfield Avenue - First Floor

Pittsburgh, Pennsylvania 15205

(412) 922-5330

(800) 242-2539 (for long distance calls within Pennsylvania)

A complete list of the employers and employee organizations sponsoring the Plan may be obtained by participants and beneficiaries upon written request to the Plan Administrator, and is available for examination.

Employer Identification Number.

The Employer Identification Number (EIN) issued to the Board of Trustees is 23-7007718.

Type of Administration of the Plan.

The Plan is administered by the Board of Trustees of the Carpenters' of Western Pennsylvania Medical Plan.

Name and Address of Plan Administrator.

Board of Trustees
of Carpenters' of Western Pennsylvania Medical Plan
c/o Carpenters' Combined Funds, inc.
495 Mansfield Avenue - First Floor
Pittsburgh, Pennsylvania 15205

Name and Address of Administrative Manager.

James R. Klein
Carpenters' Combined Funds, Inc.
495 Mansfield Avenue - First Floor
Pittsburgh, Pennsylvania 15205

Name of Person Designated as Agent for Service of Legal Process.

Stephen J. O'Brien, Esquire
Gatz, Cohen, Segal and Koerner, P.A.
400 Law and Finance Building
Pittsburgh, Pennsylvania 15219

Service of legal process may be made on a Plan Trustee or the Administrative Manager

Name of Organization Designated as Consultant to the Trustees.

The Segal Company
130 East Ninth Street, Suite 1900
Cleveland, Ohio 44114

Name and Address of Certified Public Accountant.

Henry Rossi & Co.
Certified Public Accountants
50 Seco Road
Monroeville, Pennsylvania 15146

EMPLOYEE TRUSTEES	EMPLOYER TRUSTEES
JOHN A. BROOKS Chairman	THOMAS L. MILLETARY Co-Chairman
EDWARD R. DOMINICK	ROBERT BUECHEL
DAVID H. HOHMAN	BARRY L. LOVEDAY
DENNIS L. ROUSSEAU	JOHN P. MAFFEO, JR.
SAMUEL SHILLING	TERRENCE M. McDONOUGH
ZANE R. SMIGAS	ANDREW PETERS
JAMES T. STRUTT	VINCENT J. SICILIANO, III
RAYMOND W. VOGEL, JR.	RAYMOND A. VOLPATT, JR.
WILLIAM D. WINTER	TERRY L. WALSH

Collective Bargaining Agreements

For information on Collective Bargaining Agreements, call the Administrative Office.

Sources of Contributions to the Plan

The Plan is financed through Employer Contribution made in accordance with Collective Bargaining Agreements in force with the Western Pennsylvania Regional District Council of Carpenters.

Date of End of the Plan Year

The date of the end of the fiscal year is December 31.

Procedure to be Followed In Presenting Claims for Benefits Under the Plan

Remedies are available under the Plan for the redress of claims which are denied in whole or in part, including provisions required by Section 503 of the Employee Retirement Income Security Act.

If a member wishes to appeal a denial of claim in whole or in part, he should file a request for a review within sixty (60) days after receiving the denial; he will be informed of the time and place of the hearing of his appeal. For a complete description, see the Claims and Appeals Procedure on page 31.

Statement of Participants' and Beneficiaries' Rights under ERISA

As a participant in the Carpenters' of Western Pennsylvania Medical Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's Office, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan

Administrator is required by law to furnish each participant with a copy of this summary financial report.

• File suit in a federal court, if any materials requested are not received within thirty (30) days of the participant's request, unless the materials were not sent because of matters beyond the control of the Administrator. The court may require the Plan Administrator to pay up to $100 for each day's delay until the materials are received.

In addition to creating rights for Plan participants, ERISA imposes obligations upon the persons who are responsible for the operation of the Employee Benefit Plan. These persons are referred to in the law as "fiduciaries." Fiduciaries must act solely in the interest of the Plan participants and they must exercise prudence in the performance of their Plan duties. Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused the Plan.

No one — Employer, Union, or any other person — may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Welfare Benefit or exercising your rights under ERISA.

If your claim for a Welfare Benefit is denied, in whole or in part, you must receive a written explanation for the denial. You have the right to ask for a review and reconsideration of your claim by the Plan Administrator. If your claim, in full or in part, is again denied, you have a right to file suit in a federal or state court.

If Plan fiduciaries are misusing the Plan's money, you have a right to file suit in a federal court or request assistance from the U.S. Department of Labor.

If you are successful in your lawsuit, of whatever classification, the court may, if it so decides, require the other party to pay your legal costs, including attorney's fees. However, if you lose, the court may order you to pay these costs and fees; for example, if it finds your allegation or claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.