AMENDMENT NO. 8

TO THE IRON WORKERS DISTRICT COUNCIL OF SOUTHERN OHIO AND VICINITY BENEFIT TRUST PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

[February 1, 2015 Edition]

WHEREAS, the Board of Trustees ("Trustees") of Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust and its resulting Plan ("Plan") previously adopted an Agreement and Declaration of Trust ("Trust"), as amended and restated from time to time, and currently administers and maintains the Plan for the sole and exclusive benefit of those Participants and Beneficiaries covered thereunder; and

WHEREAS, in accordance with those documents, the Plan may be amended from time to time by the Trustees; and

WHEREAS, the Trustees desire to amend the Plan to reflect the changes to the dental program by virtue of the engagement of Delta Dental of Ohio ("Delta Dental") effective June 1, 2019, whereby the Delta Dental network will be the new dental network and, all dental services processed from such date will be processed by Delta Dental, not the Benefit Trust office.

NOW THEREFORE, BE IT RESOLVED BY THE TRUSTEES, that the Plan (and Summary Plan Description) shall be amended effective June 1, 2019, as follows:

Section titled, **Dental Benefits (for Active Participants and Dependents)**, shall be deleted in its entirety and replaced with the following new Section:

Dental Benefits

(For Active Participants and Dependents)

Effective June 1, 2019, Delta Dental of Ohio ("Delta Dental") will process dental services under the Plan and the Delta Dental network will be the new dental network.

Preventive dental care can be important. To help meet the cost of routine and unexpected dental care, the Fund provides dental benefits for Active Participants and their eligible Dependents. Participants and eligible Dependents are covered under a dental Preferred Provider Organization shared network. Please refer to the *Schedule of Dental Services and Supplies* near the back of this booklet for more details about the benefits.

Dental Covered Expenses

When you or your family needs dental care, you can choose any Dentist. The Plan will pay Covered Expenses for the services of a Dentist licensed to practice dentistry within accepted standards of dental practice, up to the calendar year maximum as listed on the applicable *Schedule of Benefits* insert to this booklet and up to the maximum allowance for dental services as listed on the *Schedule of Dental Services and Supplies* insert to this booklet. The Schedule lists the dental services that are covered under the Plan and the maximum the Plan will pay for each service.

When you need dental care:
- Schedule an appointment with the Dentist of your choice.
- File a completed claim form with Delta Dental.

The amount the Plan pays depends on the type of dental service you receive and reasonable charges. Once the calendar year maximum is reached, the Plan will not pay dental expenses for the remainder of the calendar year.

Examples of covered dental expenses include:
1. Diagnostic;
2. Preventive;
3. Restorative;
4. Endodontics;
5. Periodontics;
6. Prosthodontics;
7. Oral surgery; and
8. Other general services.

Denture Coverage

Charges for full or partial dentures or bridgework will be covered if required due to loss of natural teeth. If the denture is at least one year old and cannot be made serviceable, replacement of an existing denture will be covered. Charges for repair of an existing denture or addition of teeth to an existing denture that is not being replaced will also be covered. However, charges for more than two repairs in 12 consecutive months or for more than one reline in any 24-consecutive month period will not be covered.

Dental Expenses Not Covered

You should be aware that any expenses not listed on the *Schedule of Dental Services and Supplies* are not covered by the Plan. The fact that a Dentist may prescribe, order, recommend, or approve a service does not, of itself, make it necessary or make the charge a Covered Expense, even though the service is not specifically listed as an exclusion. In addition to any general Plan exclusions or limitations (please see the *General Plan Exclusion*s section), benefits are not paid for:

1. Precision attachments, personalization, or characterization.
2. Cosmetic or orthodontic treatment, such as braces, except charges for related extractions or space maintainers.
3. Services provided by someone other than a Dentist or Physician, except for treatment performed by a duly qualified technician under the direction of a Dentist or Physician.
4. Oral examinations and prophylaxis not separated by four consecutive months.
5. Orthodontic services and/or supplies in connection with Temporomandibular Joint Disorder (TMJ).

The Plan is the final authority for determining whether services are covered. No additional dental benefits will be paid except as otherwise specified as covered by the Plan.

Section titled, **Important Information About the Plan**, shall be revised regarding the dental vendor:

Important Information About the Plan

Dental PPO Network provided by:

Delta Dental of Ohio
P.O. Box 9085
Farmington Hills, MI 48333-9085
800-524-0149
www.deltadentaloh.com

Section titled, Schedule of Dental Services and Supplies, shall be revised to reflect the new dental vendor:

Schedule of Dental Services and Supplies

SUMMARY OF DENTAL PLAN BENEFITS

This is an overview of benefits and not a guarantee of payment.

Send paper claims and pre-determinations to:
Delta Dental of Ohio
P.O. Box 9085
Farmington Hills, MI 48333-9085
800-524-0149
www.deltadentaloh.com

In-network: Covered dental procedures completed by a dentist in the dental PPO network will be covered at 100% of the PPO fee schedule, up to $2000 per person per year.

- **Diagnostic and Preventative Services:** Includes oral examinations, cleaning for adults and children, fluoride, sealants, bitewing and full mouth series x-rays, and space maintainers.
- **Basic Services**: Includes oral surgery, extractions, endodontics, periodontics, general anesthesia or intravenous sedation, and amalgam restorations.
- **Major Services**: Includes inlays and onlays, crowns, crown and bridge repair, prosthodontics (first installation of dentures and bridges), removable bridges, and full and partial dentures.

Out-of-network: Covered dental procedures completed by a non-network dentist will be paid based on the Iron Workers Benefit Trust Schedule of Dental Benefits up to the maximum $2000 per person per year. The patient is responsible for any difference between what is paid and what the dentist charges.

Coordination of benefits: Standard coordination. The Dental Plan will consider all charges still owed by the patient after the primary insurance processes the claim, up to the Iron Workers Benefit Trust schedule of benefits. An explanation of benefits (EOB) from the primary insurance is required to process the claim.

Maximum: $2000 per person per calendar year (January 1 to December 31)
Deductible: None

X-rays are not required when submitting claims. Pre-determinations are not required for any procedures. Crowns, bridges, and full and partial dentures are paid based on the prep date of the permanent appliance.

Exclusions and limitations:

- Oral exams (including evaluations by a specialist) are payable once every four consecutive months.
- Prophylaxes (cleanings) are payable once every four consecutive months.
- Fluoride treatments are payable once every 12 consecutive months with no age limit.
- Space maintainers are Covered Services with no limitations.
- Full mouth X-rays and panoramic X-rays are payable without limitation. Bitewing X-rays are payable once every twelve-month period.
- Periapical, extra-oral posterior, and 2D cephalometric X-rays are Covered Services.
- Sealants are payable for any tooth. The surface must be free from decay and restorations.
- Crowns, inlays, onlays, and substructures are Covered Services. Veneers on incisors, cuspids and bicuspids are Covered Services.
- Composite resin (white) restorations are Covered Services on posterior teeth.
- Inlays (any material) are Covered Services.
- Gold foils are Covered Services.
- Porcelain and resin facings on crowns are Covered Services on posterior teeth.
- Canal preparation and fitting of performed dowel or post are Covered Services.
- Gingivectomy or gingivoplasty to allow access for restorative procedures, provisional splinting, and localized delivery of chemotherapeutic agents are Covered Services.
- Certain oral surgery procedures including oroantral fistula closure, placement of temporary anchorage device, vestibuloplasty, incision and drainage of extraoral soft tissue; removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue; removal of reaction producing foreign bodies, partial ostectomy/sequestrectomy for removal of non-vital bone, maxillary sinusotomy for removal of tooth fragment or foreign body, frenulectomy and frenuloplasty are Covered Services.
- Full and partial dentures are payable once every twelve-month period. Reline and rebase of dentures and tissue conditioning are Covered Services.
- Bridges are payable once in any twelve-month period. Fixed Partial Denture single crowns/major restorative are Covered Services.
- Porcelain and resin facings on bridges are Covered Services on posterior teeth.
- Implants are payable once per tooth per lifetime. Implant related services are Covered Services.
- Services related to crowns over implants are Covered Services. Implant supported prosthetics are Covered Services once every twelve-month period.
- Office visits for observation, therapeutic parenteral drug administration, drugs or medicaments dispensed in the office for home use, application of desensitizing medicament and desensitizing resin, and occlusal guards are Covered Services.
- Removable harmful habit appliances are Covered Services.

Diagnostic		
D0120	Periodic oral evaluation	$66.50
D0140	Limited oral evaluation	$66.50
D0145	Oral evaluation for patient under three years of age and counseling with primary caregiver	$51.25
D0150	Comprehensive oral evaluation	$66.50
D0160	Detailed and extensive oral evaluation	$66.50
D0180	Comprehensive periodontal evaluation	$66.50
D0210	Intraoral – complete series of radiographic images	$91.50
D0220	Intraoral – periapical first radiographic image	$18.75
D0230	Intraoral – periapical each additional radiographic image	$16.00
D0240	Intraoral – occlusal radiographic image	$27.75
D0250	Extra-oral 2D projection radiographic image created using a stationary radiation source, and detector	$36.25
D0251	Extra-oral posterior dental radiographic image	$36.25
D0270	Bitewing – single radiographic image	$20.00
D0272	Bitewings – two radiographic images	$32.25
D0273	Bitewings – three radiographic images	$39.00
D0274	Bitewings – four radiographic images	$45.00
D0277	Vertical bitewings – 7 to 8 radiographic images	$68.00
D0330	Panoramic radiographic image	$76.50
D0340	2D cephalometric radiographic image	$94.75
D0460	Pulp vitality tests	$30.25
Preventive		
D1110	Prophylaxis – adult	$55.75
D1120	Prophylaxis – child	$43.50
D1206	Topical application of fluoride varnish	$38.75
D1208	Topical application of fluoride – excluding varnish	$24.75
D1351	Sealant – per tooth	$35.00
D1353	Sealant repair – per tooth	$35.00
D1510	Space maintainer – fixed, unilateral	$148.75
D1516	Space maintainer – fixed – bilateral, maxillary	$196.50
D1517	Space maintainer – fixed – bilateral, mandibular	$196.50
D1520	Space maintainer – removable – unilateral	$178.50
D1526	Space maintainer – removable – bilateral, maxillary	$252.50
D1527	Space maintainer – removable – bilateral, mandibular	$252.50
D1550	Re-cement or re-bond space maintainer	$32.25
D1555	Removal of fixed space maintainer	$29.75
Restorative		
D2140	Amalgam – one surface, primary or permanent	$70.50
D2150	Amalgam – two surfaces, primary or permanent	$86.75
D2160	Amalgam – three surfaces, primary or permanent	$106.50
D2161	Amalgam – four or more surfaces, primary or permanent	$129.50
D2330	Resin-based composite – one surface, anterior	$71.25
D2331	Resin-based composite – two surfaces, anterior	$86.75
D2332	Resin-based composite – three surfaces, anterior	$106.25
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	$125.50
D2390	Resin-based composite crown, anterior	$139.25
D2391	Resin-based composite – one surface, posterior	$76.50
D2392	Resin-based composite – two surfaces, posterior	$100.50
D2393	Resin-based composite – three surfaces, posterior	$129.50
D2394	Resin-based composite – four surfaces, posterior	$158.50
D2410	Gold foil – one surface	$131.00
D2420	Gold foil – two surfaces	$218.25
D2430	Gold foil – three surfaces	$378.50
D2510	Inlay – metallic – one surface	$346.50
D2520	Inlay – metallic – two surfaces	$393.00
D2530	Inlay – metallic – three or more surfaces	$453.00
D2542	Onlay – metallic – one surface	$444.25
D2543	Onlay – metallic – two surfaces	$464.75
D2544	Onlay – metallic – three or more surfaces	$483.25

D2610	Inlay – porcelain/ceramic – one surface	$407.50
D2620	Inlay – porcelain/ceramic – two surfaces	$430.25
D2630	Inlay – porcelain/ceramic – three or more surfaces	$458.25
D2642	Onlay – porcelain/ceramic – two surfaces	$445.50
D2643	Onlay – porcelain/ceramic – three surfaces	$480.25
D2644	Onlay – porcelain/ceramic – four or more surfaces	$509.50
D2650	Inlay – resin-based composite – one surface	$267.75
D2651	Inlay – resin-based composite – two surfaces	$319.00
D2652	Inlay – resin-based composite – three or more surfaces	$335.50
D2662	Onlay – resin-based composite – two surfaces	$291.00
D2663	Onlay – resin-based composite – three surfaces	$342.50
D2664	Onlay – resin-based composite – four or more surfaces	$366.75
D2710	Crown – resin-based composite (indirect)	$206.75
D2720	Crown – ¾ resin-based composite (indirect)	$509.50
D2721	Crown – resin with predominantly base metal	$477.50
D2722	Crown – resin with noble metal	$488.00
D2740	Crown – porcelain/ceramic	$522.75
D2750	Crown – porcelain fused to high noble metal	$506.75
D2751	Crown – porcelain fused to predominantly base metal	$480.25
D2752	Crown – porcelain fused to noble metal	$492.00
D2780	Crown – ¾ cast high noble metal	$494.75
D2781	Crown – ¾ cast predominantly base metal	$465.75
D2782	Crown – ¾ cast noble metal	$481.00
D2783	Crown – ¾ porcelain/ceramic	$508.75
D2790	Crown – full cast high noble metal	$497.75
D2791	Crown – full cast predominantly base metal	$471.50
D2792	Crown – full cast noble metal	$480.25
D2799	Provisional crown – further treatment or completion of diagnosis necessary prior to final impression	$206.50

D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$50.75
D2920	Re-cement or re-bond crown	$51.25
D2929	Prefabricated porcelain/ceramic crown – primary tooth	$150.00
D2930	Prefabricated stainless steel crown – primary tooth	$140.00
D2931	Prefabricated stainless steel crown – permanent tooth	$158.25
D2932	Prefabricated resin crown	$168.75
D2933	Prefabricated stainless steel crown with resin window	$193.25
D2940	Protective restoration	$53.50
D2950	Core buildup, including any pins when required	$126.50
D2951	Pin retention – per tooth, in addition to restoration	$30.25
D2952	Post and core in addition to crown, indirectly fabricated	$211.00
D2953	Each additional indirectly fabricated post – same tooth	$105.50
D2954	Prefabricated post and core in addition to crown	$168.75
D2960	Labial veneer (resin laminate) – chairside	$407.75
D2961	Labial veneer (resin laminate) – laboratory	$462.50
D2962	Labial veneer (porcelain laminate) – laboratory	$502.75
D2980	Crown repair necessitated by restorative material failure	$94.00
D2981	Inlay repair necessitated by restorative material failure	$125.00
D2982	Onlay repair necessitated by restorative material failure	$139.00
D2983	Veneer repair necessitated by restorative material failure	$139.00
Endodontics		
D3110	Pulp cap – direct (excluding final restoration)	$36.00
D3120	Pulp cap – indirect (excluding final restoration)	$29.75
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	$85.00
D3221	Pulpal debridement, primary and permanent teeth	$93.25

D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	$138.49
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$359.00
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$438.50
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$566.25
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$276.25
D3346	Retreatment of previous root canal therapy - anterior	$483.25
D3347	Retreatment of previous root canal therapy - premolar	$569.50
D3348	Retreatment of previous root canal therapy - molar	$682.50
D3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$283.25
D3410	Apicoectomy – anterior	$410.75
D3421	Apicoectomy – premolar (first root)	$448.75
D3425	Apicoectomy – molar (first root)	$507.50
D3426	Apicoectomy (each additional root)	$169.25
D3430	Retrograde filling – per root	$124.25
D3450	Root amputation – per root	$252.00
D3950	Canal preparation and fitting of preformed dowel or post	$174.66
Periodontics		
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	$431.50
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	$181.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$181.00
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant	$509.50
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant	$265.25
D4249	Clinical crown lengthening – hard tissue	$578.50
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$829.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$432.00
D4263	Bone replacement graft – retained natural tooth – first site in quadrant	$259.25
D4264	Bone replacement graft – retained natural tooth – each additional site in quadrant	$138.25
D4266	Guided tissue regeneration – resorbable barrier, per site	$302.50
D4267	Guided tissue regeneration – non-resorbable barrier, per site (includes membrane removal)	$388.75
D4268	Surgical revision procedure, per tooth	$755.00
D4270	Pedicle soft tissue graft procedure	$604.75
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position in graft	$740.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$209.00
D4275	Non-autogenous connective tissue graft procedure (including recipient and donor material) first tooth, implant or edentulous tooth position in graft	$388.75
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$630.75
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	$315.50
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) each additional contiguous tooth,	$370.00

	implant or edentulous tooth position in same graft site	
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) each additional contiguous tooth, implant or edentulous tooth position in same graft site	$157.75
D4320	Provisional splinting – intracoronal	$218.50
D4321	Provisional splinting – extracoronal	$191.00
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	$120.75
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	$65.50
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	$65.00
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	$79.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$73.75
D4910	Periodontal maintenance	$59.25
Prosthodontics		
D5110	Complete denture, maxillary	$798.00
D5120	Complete denture, mandibular	$798.00
D5130	Immediate denture, maxillary	$870.50
D5140	Immediate denture, mandibular	$870.50
D5211	Maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)	$783.00
D5212	Mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	$783.00
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any convention clasps, rests, and teeth)	$882.00
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	$882.00
D5221	Immediate maxillary partial denture – resin base (including any conventional clasps, rests, and tooth)	$783.00
D5222	Immediate mandibular partial denture – resin base (including any conventional clasps, rests, and teeth)	$783.00
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	$882.00
D5224	Immediate mandibular partial denture – cast metal framework with resin dentures bases (including any conventional clasps, rests, and teeth)	$882.00
D5225	Maxillary partial denture – flexible base (including any clasps, rests, and teeth)	$783.00
D5226	Mandibular partial denture – flexible base (including any clasps, rests, and teeth)	$783.00
D5282	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary	$514.00
D5283	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular	$514.00
D5410	Adjust complete denture – maxillary	$43.75
D5411	Adjust complete denture – mandibular	$43.75
D5421	Adjust partial denture – maxillary	$43.75
D5422	Adjust partial denture – mandibular	$43.75
D5511	Repair broken complete denture base, mandibular	$87.45
D5512	Repair broker complete denture base, maxillary	$87.45
D5520	Replace missing or broken teeth – complete denture (each tooth)	$72.75
D5611	Repair resin partial denture base, mandibular	$94.75
D5612	Repair resin partial denture base, maxillary	$94.75
D5621	Repair cast partial framework, mandibular	$102.00
D5622	Repair cast partial framework, maxillary	$102.00
D5630	Repair or replace broken retentive/clasping materials – per tooth	$123.75
D5640	Replace broken teeth – per tooth	$80.25
D5650	Add tooth to existing partial denture	$109.25

D5660	Add clasp to existing partial denture – per tooth	$131.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$320.50
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$320.50
D5710	Rebase complete maxillary denture	$324.00
D5711	Rebase complete mandibular denture	$324.00
D5720	Rebase maxillary partial denture	$306.00
D5721	Rebase mandibular partial denture	$306.00
D5730	Reline complete maxillary denture (chairside)	$182.75
D5731	Reline complete mandibular denture (chairside)	$182.75
D5740	Reline maxillary partial denture (chairside)	$167.50
D5741	Reline mandibular partial denture (chairside)	$167.50
D5750	Reline complete maxillary denture (laboratory)	$244.00
D5751	Reline complete mandibular denture (laboratory)	$244.00
D5760	Reline maxillary partial denture (laboratory)	$240.25
D5761	Reline mandibular partial denture (laboratory)	$240.25
D5810	Interim complete denture (maxillary)	$415.25
D5811	Interim complete denture (mandibular)	$415.25
D5820	Interim partial denture (maxillary)	$316.75
D5821	Interim partial denture (mandibular)	$316.75
D5850	Tissue conditioning, maxillary	$76.50
D5851	Tissue conditioning, mandibular	$76.50
D5862	Precision attachment, by report	$250.75
D5863	Overdenture – complete maxillary	$752.50
D5864	Overdenture – partial maxillary	$776.25
D5865	Overdenture – complete mandibular	$752.50
D5866	Overdenture – partial mandibular	$776.25
D5982	Surgical stent	$397.00
Implants		
D6010	Surgical placement of implant body: endosteal implant	$1333.75
D6013	Surgical placement of mini implant	$531.75
D6056	Prefabricated abutment – includes modification and placement	$342.00
D6057	Custom fabricated abutment – includes placement	$418.50
D6058	Abutment supported porcelain/ceramic crown	$735.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$714.75
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$642.00
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$678.00
D6062	Abutment supported cast metal crown (high noble metal)	$694.50
D6063	Abutment supported cast metal crown (predominantly base metal)	$633.75
D6064	Abutment supported cast metal crown (noble metal)	$642.00
D6065	Implant supported porcelain/ceramic crown	$735.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$714.75
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$678.00
D6068	Abutment supported retainer for porcelain/ceramic FPD	$735.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$714.75
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$642.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$678.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$678.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$621.75
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$642.00
D6075	Implant supported retainer for ceramic FPD	$735.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	$714.75

D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	$678.00
D6080	Implant maintenance procedures when prostheses are removed or reinserted, including cleansing of prostheses and abutments	$43.50
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	$89.25
D6090	Repair implant supported prosthesis, by report	$412.50
D6092	Re-cement or re-bond implant/abutment supported crown	$43.50
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	$58.50
D6094	Abutment supported crown (titanium)	$618.75
D6095	Repair implant abutment, by report	$412.50
D6096	Remove broken implant retaining screw	$127.50
D6100	Implant removal, by report	$253.50
D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	$327.00
D6102	Debridement of osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	$471.00
D6103	Bone graft for repair of peri-implant defect – does not include flap entry and closure	$236.25
D6104	Bone graft at time of implant placement	$472.50
D6110	Implant/abutment supported removable denture for edentulous arch – maxillary	$1723.90
D6111	Implant/abutment supported removable denture for edentulous arch – mandibular	$1723.90
D6112	Implant/abutment supported removable denture for partially edentulous arch – maxillary	$1723.90
D6113	Implant/abutment supported removable denture for partially edentulous arch – mandibular	$1723.90
D6114	Implant/abutment supported fixed denture for edentulous arch – maxillary	$5500.00
D6115	Implant/abutment supported fixed denture for edentulous arch – mandibular	$5500.00
D6116	Implant/abutment supported fixed denture for partially edentulous arch – maxillary	$5500.00
D6117	Implant/abutment supported fixed denture for partially edentulous arch – mandibular	$5500.00
D6194	Abutment supported retainer crown for FPD (titanium)	$714.75
D6199	Unspecified implant procedure, by report	$412.50
D6205	Pontic – indirect resin based composite	$644.13
D6210	Pontic – cast high noble metal	$509.25
D6211	Pontic – cast predominantly base metal	$477.25
D6212	Pontic – cast noble metal	$496.50
D6214	Pontic – titanium	$512.50
D6240	Pontic – porcelain fused to high noble metal	$503.00
D6241	Pontic – porcelain fused to predominantly base metal	$464.50
D6242	Pontic – porcelain fused to noble metal	$490.00
D6245	Pontic – porcelain/ceramic	$519.00
D6250	Pontic – resin with high noble metal	$496.50
D6251	Pontic – resin with predominantly base metal	$458.00
D6252	Pontic – resin with high noble	$472.75
D6253	Provisional pontic- further treatment or completion of diagnosis necessary prior to final impression	$214.00
D6545	Retainer – cast metal for resin bonded fixed prosthesis	$211.50
D6548	Retainer – porcelain/ceramic for resin bonded fixed prosthesis	$232.50
D6549	Resin retainer – for resin bonded fixed prosthesis	$200.00
D6600	Retainer inlay – porcelain/ceramic, two services	$419.50
D6601	Retainer inlay – porcelain/ceramic, three or more surfaces	$440.00

D6602	Retainer inlay – cast high noble metal, two surfaces	$448.50
D6603	Retainer inlay – cast high noble metal, three or more surfaces	$493.25
D6604	Retainer inlay – cast predominantly base metal, two surfaces	$439.50
D6605	Retainer inlay – cast predominantly base metal, three or more surfaces	$465.75
D6606	Retainer inlay – cast noble metal, two surfaces	$432.50
D6607	Retainer inlay – cast noble metal, three or more surfaces	$479.75
D6608	Retainer onlay – porcelain/ceramic, two surfaces	$456.25
D6609	Retainer onlay – porcelain/ceramic, three or more surfaces	$476.00
D6610	Retainer onlay – cast high noble, two surfaces	$483.50
D6611	Retainer onlay – cast high noble, three or more surfaces	$529.25
D6612	Retainer onlay – cast predominantly base metal, two surfaces	$481.00
D6613	Retainer onlay – cast predominantly base metal, three or more surfaces	$502.50
D6614	Retainer onlay – cast noble metal, two surfaces	$470.75
D6615	Retainer onlay – cast noble metal, three or more surfaces	$489.00
D6634	Retainer onlay – titanium	$471.00
D6710	Retainer crown – indirect resin based composite	$480.50
D6720	Retainer crown – resin with high noble metal	$560.50
D6721	Retainer crown – resin with predominantly base metal	$531.50
D6722	Retainer crown – resin with noble metal	$541.00
D6740	Retainer crown – porcelain/ceramic	$589.00
D6750	Retainer crown – porcelain fused to high noble metal	$574.00
D6751	Retainer crown – porcelain fused to predominantly base metal	$535.50
D6752	Retainer crown – porcelain fused to noble metal	$548.00
D6780	Retainer crown – ¾ cast high noble metal	$541.00
D6781	Retainer crown – ¾ cast predominantly base metal	$541.00
D6782	Retainer crown – ¾ cast noble metal	$502.50
D6783	Retainer crown – ¾ porcelain/ceramic	$557.25
D6790	Retainer crown – full cast high noble metal	$554.25
D6791	Retainer crown – full cast predominantly base metal	$525.25
D6792	Retainer crown – full cast noble metal	$544.50
D6793	Provisional retainer crown – further treatment of completion of diagnosis necessary prior to final impression	$227.25
D6794	Retainer crown – titanium	$544.50
D6930	Re-cement or re-bond fixed partial denture	$67.25
D6940	Stress breaker	$152.50
Oral Surgery		
D7111	Extraction, coronal remnants – primary tooth	$86.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$112.25
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$207.75
D7220	Removal of impacted tooth – soft tissue	$239.00
D7230	Removal of impacted tooth – partially bony	$318.00
D7240	Removal of impacted tooth – completely bony	$373.00
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	$469.00
D7250	Removal of residual tooth roots (cutting procedure)	$201.50
D7251	Coronectomy – intentional partial tooth removal	$128.00
D7260	Oroantral fistula closure	$1678.50
D7280	Exposure of an unerupted tooth	$345.75
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$162.00
D7283	Placement of device to facilitate eruption of impacted tooth	$108.75
D7290	Surgical repositioning of teeth	$365.50
D7292	Placement of temporary anchorage device requiring flap; includes device removal	$543.00

D7293	Placement of temporary anchorage device requiring flap; include device removal	$345.75
D7294	Place of temporary anchorage device without flap; includes device removal	$250.00
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$222.25
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$360.46
D7320	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$321.00
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	$1777.50
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$2000.00
D7473	Removal of torus mandibularis	$302.00
D7510	Incision and drainage of abscess – intraoral soft tissue	$212.25
D7520	Incision and drainage of abscess – extraoral soft tissue	$1011.25
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	$364.50
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$403.25
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$251.75
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$1999.50
D7960	Frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure	$217.00
D7963	Frenuloplasty	$997.22
D7971	Excision of hyperplastic tissue – per arch	$153.00
Orthodontics		
D8210	Removal appliance therapy	$187.50
Adjunctive Services		
D9110	Palliative (emergency) treatment of dental pain – minor procedure	$57.75
D9120	Fixed partial denture sectioning	$65.25
D9211	Regional block anesthesia	$26.25
D9212	Trigeminal division block anesthesia	$52.50
D9222	Deep sedation/general anesthesia – first 15 minutes	$107.00
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	$107.00
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes	$84.00
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	$84.00
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	$120.00
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	$37.50
D9440	Office visit – after regularly scheduled hours	$75.00
D9610	Therapeutic parenteral drug, single administration	$24.50
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	$49.00
D9630	Drugs or medicaments dispensed in the office for home use	$24.50
D9910	Application of desensitizing medicament	$26.25
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	$42.00
D9944	Occlusal guard – hard appliance, full arch	$187.50
D9946	Occlusal guard – hard appliance, partial arch	$140.50
D9951	Occlusal adjustment – limited	$73.50
D9952	Occlusal adjustment - complete	$412.50

Section titled, **Contact Information**, shall be revised regarding the dental vendor:

Contact Information

If You Need Information About …	Contact …
▪ Dental PPO Network	**Delta Dental of Ohio** P.O. Box 9085 Farmington Hills, MI 48333-9085 800-524-0149 www.deltadentaloh.com

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AMENDMENT NO. 9

TO THE IRON WORKERS DISTRICT COUNCIL OF SOUTHERN OHIO AND VICINITY BENEFIT TRUST PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

[February 1, 2015 Edition]

WHEREAS, the Board of Trustees ("Trustees") of Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust and its resulting Plan ("Plan") previously adopted an Agreement and Declaration of Trust ("Trust"), as amended and restated from time to time, and currently administers and maintains the Plan for the sole and exclusive benefit of those Participants and Beneficiaries covered thereunder; and

WHEREAS, in accordance with those documents, the Plan may be amended from time to time by the Trustees; and

WHEREAS, the Trustees desire to amend the Plan to exclude gene therapies and gene therapy drugs from coverage under the Active and Non-Medicare Retiree Plans.

NOW THEREFORE, BE IT RESOLVED BY THE TRUSTEES, that the Active and Non-Medicare Retiree Plans (and Summary Plan Description), shall be amended effective May 14, 2019, as set forth below.

The Section titled, **Medical Benefits (For Active Participants, Non-Medicare Eligible Retirees, and Dependents)**, shall be amended to reflect the gene therapy exclusion:

Medical Benefits

(For Active Participants, Non-Medicare Eligible Retirees, and Dependents)

* * *

Therapy Services

IMPORTANT NOTE: Gene Therapies are excluded from coverage.

Benefits for therapy services when provided as part of Physician office services, Inpatient services, Outpatient services, or home care services are limited to the following:

- Physical medicine therapies where the expectation exists that the therapy will result in a practical improvement in the level of functioning within a reasonable period;
- Physical therapy including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices, provided such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part;
- Speech therapy for the correction of a speech impairment;

- Occupational therapy for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living, including tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, and vocational therapies (such as hobbies, arts and crafts);
- Spinal manipulation services to correct by manual or mechanical means structural imbalance or subluxation to remove nerve interference from or related to distortion, misalignment, or subluxation of or in the vertebral column. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for spinal manipulation services as listed on the applicable *Schedule of Benefits* insert to this booklet;
- Cardiac rehabilitation to restore an individual's functional status after a cardiac event. Home programs, on-going conditioning, and maintenance are not covered;
- Chemotherapy for the treatment of disease by chemical or biological antineoplastic agents, including the cost of such agents;
- Dialysis treatments of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine;
- Radiation therapy for the treatment of disease by X-ray, radium, or radioactive isotopes; and
- Inhalation therapy for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. See the applicable *Schedule of Benefits* insert to this booklet for benefit limitations.

* * *

Medical Expenses Not Covered

You should be aware that not every medical expense is covered by the Plan. For a list of expenses not covered by the Plan, please see the *General Plan Exclusions* section.

The Section titled, **Prescription Drug Benefits (For Active Participants, Non-Medicare Eligible Retirees, and Dependents)**, shall be amended to reflect the gene therapy exclusion:

Prescription Drug Benefits

(For Active Participants, Non-Medicare Eligible Retirees, and Dependents)

* * *

Prescription Drug Expenses Not Covered

This section includes information on prescription drug coverage for Active Participants, Non-Medicare Retirees, and Dependents. *Medicare-eligible Retiree coverage is not described in this booklet.*

In addition to any general Plan exclusions or limitations (please see the *General Plan Exclusions* section), benefits are not paid for:

1. Drugs, devices, products, or Prescription Legend Drugs with over the counter equivalents and any drugs, devices, or products that are therapeutically comparable to an over the counter drug, device, or product.
2. Off label use, except as otherwise prohibited by law or as approved by the Plan.

3. Drugs in quantities exceeding the quantity prescribed or for any refill dispensed later than one year after the date of the original prescription order.
4. Charges for the administration of any drug.
5. Drugs consumed at the time and place where dispensed or where the prescription order is issued, including, but not limited to, samples provided by a Physician. This does not apply to drugs used in conjunction with a Diagnostic Service, chemotherapy performed in the office, or drugs eligible for coverage under the Medical Supplies benefit.
6. Any drug that is primarily for weight loss, except certain drugs for the treatment of morbid obesity may be covered based on Medical Necessity.
7. Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not by federal law) except for injectable insulin.
8. Drugs in quantities that exceed the limits established by the Plan or that exceed any age limits established by the Plan.
9. Any drug that is primarily for cosmetic purposes (including, but not limited to, preserving, changing, or improving appearance, such as changing the appearance or texture of skin).
10. Contraceptive devices, oral immunizations, and biologicals, although they are federal legend drugs, are payable as medical supplies based on where the service is performed or the item is obtained. If such items are over-the-counter drugs, devices, or products, they are not Covered Services.
11. Any new FDA approved drug product or technology (including, but not limited to, medications, medical supplies, or devices available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to pharmacies, for the first six months after the product or technology received FDA new drug approval or other applicable FDA approval). The Plan may in its sole discretion, waive this exclusion in whole or in part for a specific new FDA approved drug product or technology.
12. Fertility drugs.
13. Gene Therapy drugs.

The Plan is the final authority for determining what medications are covered. No additional prescription drug benefits will be paid except as otherwise specified as covered by the Plan.

The Section titled, **General Plan Exclusions**, shall be amended to reflect the gene therapy exclusion:

General Plan Exclusions

The following list of exclusions applies to all such charges, unless an exception is stated, and applies to all benefits provided under the Plan. In addition to the exclusions listed under each benefit section, no benefits are payable under the Plan for:

1. Any procedure, equipment, service, or supply that is not determined to be Medically Necessary or that does not meet the Plan's third-party administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines.

2. Any procedure, equipment, service, or supply received from an individual or entity that is not a Provider as defined by the Plan or recognized by the Plan's third-party administrator on behalf of the Plan.

3. Any Experimental or Investigational procedure, equipment, service or supply, or related to such, whether incurred before, in connection with, or subsequent to the Experimental or Investigational service or supply, as determined by the Plan or the Plan's third-party administrator on behalf of the Plan.

4. Any condition, disease, defect, ailment, or injury arising out of and/or in the course of employment for wage or profit, or covered under any Workers' Compensation act or other similar law, regardless of whether:

   a. You receive the benefits in whole or in part;

   b. You claim the benefits or compensation; or

   c. You recover from any third party.

5. Any benefit provided through any governmental unit (except Medicaid), unless otherwise required by law or regulation. The payment of benefits under the Plan will be coordinated with such governmental units to the extent required under existing state or federal laws.

6. Any condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.

7. Any care required while incarcerated in a federal, state, or local penal institution or required while in custody of federal, state, or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

8. Any illness or injury that occurs as a result of any act of war, declared or undeclared, or while serving in the armed forces.

9. Any prescription drug expenses you are responsible for under other coverage with other carriers or health plans.

10. Any membership, administrative, or access fee charged by Physicians or other Providers, including, but not limited to, fees charged for educational brochures or calling a patient to provide test results.

11. Any court-ordered testing or care unless Medically Necessary and certified by the Plan or the Plan's third party administrator on behalf of the Plan;

12. Any expense that you have no legal obligation to pay in the absence of this or like coverage.

13. Any procedure, equipment, service, or supply received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group.

14. Any procedure, equipment, service, or supply prescribed, ordered, referred by, or received from a member of your immediate family (i.e., parent, child, spouse, sister, brother, or self).

15. Completion of claim forms or charges for medical records or reports unless otherwise required by law.

16. Missed or canceled appointments.

17. Mileage costs or other travel expenses, except as certified by the Plan or the Plan's third party administrator on behalf of the Plan.

18. Which benefits are payable under Medicare Part A and/or Medicare Part B or would have been payable if a member had applied for Part A and/or Part B, except, as specified elsewhere in this Plan or as otherwise prohibited by federal law.

19. Charges in excess of the Maximum Allowable Amount.

20. Charges incurred before the Effective Date of coverage.

21. Charges incurred after the termination date of this coverage except as specified elsewhere in this Plan.

22. Any procedures, services, equipment, or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change, or improve appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of skin or to change the size, shape, or appearance of facial or body features (such as nose, eyes, ears, cheeks, chin, chest, or breasts), except benefits are provided for a reconstructive service performed to correct a physical functional impairment of any area caused by disease, trauma, congenital anomalies, or previous therapeutic process. Reconstructive services are payable only if the original procedure would have been a Covered Service under the Plan. Other reconstructive services are not covered except as otherwise required by law.

23. Any procedure, equipment, service, or supply to maintain or preserve the present level of function or prevent regression of functions for an illness, injury, or condition that is resolved or stable.

24. Custodial, Domiciliary, or Convalescent Care whether or not recommended or performed by a professional.

25. Foot care to improve comfort or appearance including, but not limited to, care for flat feet, subluxations, corns, bunions (except capsular and bone surgery), calluses, and toenails except when Medically Necessary including, but not limited to, foot care diagnosis of diabetes or for impaired circulation to the lower extremities.

26. Any treatment for teeth, gums, or tooth related service except as otherwise specified as covered by the Plan.

27. Weight loss or weight loss programs whether or not they are under medical or Physician supervision or for medical reasons. Weight loss programs include, but are not limited to,

commercial weight loss programs such as Weight Watchers, Jenny Craig, LA Weight Loss or fasting programs.

28. Bariatric surgery, regardless of its proposed purpose. This includes, but is not limited to, roux-en-y (rny), laparoscopic gastric bypass surgery, other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), gastroplasty (surgical procedures that decreases the size of the stomach), or gastric banding procedures.

29. Treatment related to or in connection with gender dysphoria, including sex transformation surgery and related services or the reversal thereof.

30. Marital counseling or personal growth counseling.

31. Routine vision examinations except as otherwise specified as covered by the Plan.

32. Routine hearing care except as otherwise specified as covered by the Plan.

33. Prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specified as covered by the Plan. This exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery or for soft contact lenses due to a medical condition.

34. Hearing aids or examinations for prescribing or fitting them except as otherwise specified as covered by the Plan.

35. Any procedure, equipment, service, or supply primarily for educational, vocational, or training purposes except otherwise specified as covered by the Plan.

36. Reversal of sterilization.

37. Artificial insemination, fertilization (such as invitro or gift), procedures, or testing related to fertilization, infertility drugs, or related services following a diagnosis of infertility.

38. Personal hygiene, environmental control, or convenience items including, but not limited to, air conditioners, humidifiers, physical fitness equipment, personal comfort and convenience items during an Inpatient stay (including, but not limited to daily television rental, telephone services, cots or visitor's meals), charges for failure to keep a scheduled visit or non-medical self-care (except as otherwise stated), and purchase or rental of supplies for common household use (such as exercise cycles, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows, mattresses, waterbeds, treadmill or special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program).

39. Telephone consultations or consultations via electronic mail or internet/Web site except as required by law or as otherwise certified.

40. Care received in an emergency room that is not Emergency Care.

41. Eye surgery to correct errors of refraction, such as near-sightedness, including without limitation, radial keratotomy, keratomileusis, or excimer laser photo refractive keratectomy.

42. Artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This exclusion includes services for implantation, removal, and complications. This exclusion does not apply for left ventricular assist devices (LVAD) when used as a bridge to a heart transplant.

43. Any procedure, equipment, service, or supply related to alternative or complementary medicine. Such services include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aromatherapy, massage therapy, reike therapy, herbal, vitamin, or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (best), and iridology (study of the iris).

44. Expenses incurred at a health spa or similar facility.

45. Self-help training and other forms of non-medical self-care except as otherwise specified as covered by the Plan.

46. Research studies or screening examinations except as otherwise specified as covered by the Plan.

47. Stand-by Physician charges.

48. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

49. Private duty nursing services rendered in a Hospital or Skilled Nursing Facility.

50. Private duty nursing services except when provided through home care services benefit.

51. Drugs quantities that exceed Plan limits.

52. Any new FDA approved drug product or technology (including, but not limited to, medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to, pharmacies, for the first six months after the product or technology received FDA new drug approval or other applicable FDA approval. The Plan may, at its sole discretion, waive this exclusion in whole or in part for a specific new FDA approved drug product or technology.

53. Treatment or service not prescribed by a Physician.

54. Charges for books and supplies for music and/or art therapy.

55. Surgery performed for the removal of excess fat in any body area or resection of excess skin or fat following weight loss or pregnancy.

56. Treatment or service in connection with or to rule out the pregnancy of a Dependent child.

57. Expense incurred for donation or transplant of an organ or tissue when the recipient is not covered under this Plan.

58. Nicotine gum or Nicorette whether or not prescribed by a Physician.

59. Treatment of injury received or sickness contracted as a result of committing or attempting to commit a criminal act.

60. Injuries resulting from travel on any type of non-commercial aircraft.

61. Gene Therapies.

AMENDMENT NO. 10

TO THE IRON WORKERS DISTRICT COUNCIL OF SOUTHERN OHIO AND VICINITY BENEFIT TRUST PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

[February 1, 2015 Edition]

WHEREAS, the Board of Trustees ("Trustees") of Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust and its resulting Plan ("Plan") previously adopted an Agreement and Declaration of Trust ("Trust"), as amended and restated from time to time, and currently administers and maintains the Plan for the sole and exclusive benefit of those Participants and Beneficiaries covered thereunder; and

WHEREAS, in accordance with those documents, the Plan may be amended from time to time by the Trustees; and

WHEREAS, the Trustees desire to amend the Plan to reflect the loss of grandfathered status based on Plan design changes effective January 1, 2020; and

WHEREAS, the Trustees desire to amend the Plan to clarify the default rule for new employee eligibility.

NOW THEREFORE, BE IT RESOLVED BY THE TRUSTEES, that the Plan (and Summary Plan Description), shall be amended as set forth below.

Effective January 1, 2020, the Plan shall forego grandfathered status and the respective **Schedule of Benefits** shall be modified as set forth in **Schedule 1** with respect to the medical deductibles, out-of-pocket maximums, and preventative care, as well as the prescription deductibles, co-payments and out-of-pocket maximums.

Effective January 1, 2020, remove **example** at page 29 of the Plan Document and Summary Plan Description in light of increased deductible.

Effective January 1, 2020, the Plan shall add the following external claims review process to the Section entitled, **How to File Claims and Appeals**:

EXTERNAL REVIEW PROCESS

- **Claims Adjudicated by the Plan's third-party administrator.**

- **First Level Appeal**:

  With respect to those claims adjudicated by the Plan's third-party administrator, the Claimant is required to appeal any adverse benefit determination directly to the Plan's third-party administrator in accordance with these procedures.

- **Second Level Appeal:**

Once the Claimant receives the Plan's third-party administrator determination on such appeal, the Claimant has the right to a second-level external review through an Independent Review Organization (IRO), if certain criteria are met. The request for external review must be made within four (4) months from the Claimant's receipt of the adverse benefit determination from the Plan's third-party administrator. The Claimant may be eligible to have a decision reviewed through the external review process if the following criteria are met:

- The adverse benefit determination involves medical judgment, as determined by the external reviewer, or a rescission of coverage;
- The mandatory internal appeal process has been exhausted unless under applicable law you are not require to exhaust the internal appeal process (for example, when your claim is entitled to expedited external review and you request an expedited external review to proceed simultaneously with an urgent internal appeal, or if you do not receive a timely internal appeal decision);
- The Claimant is or was covered under the Plan at the time the service was requested, or, in the case of retrospective review, was covered under the Plan when the service was provided, and;
- The Claimant has provided all of the information and forms necessary to process the external review.

The external review will be conducted by an IRO accredited by a nationally recognized accrediting organization. The Claimant will not be required to pay for any part of the cost of the external review. All IROs act independently and impartially and are assigned to review the claim on a rotational basis or by another unbiased method of selection. The decision to use an IRO is not based in any manner on the likelihood that the IRO will support a denial of benefits.

The IRO conducting the review will be provided with a copy of the records that are relevant to your medical condition and the external review. The IRO will review the claim without being bound by any decisions or conclusions reached during the internal claim and appeal process.

- **External Review for Non-Urgent Care Claim Appeals**

If the Claimant's request for external review is complete and the Claimant is eligible for external review, an IRO will conduct the interview. The IRO will notify the Claimant and give the Claimant ten (10) business days to submit information for its consideration. The IRO will issue a written decision within 45 days after it receives the request for external review. This written decision will include the main reasons for the decision, including the rationale for the decision.

- **Expedited External Review for Urgent Care Claim Appeals**

The Claimant may request an external review for urgent care claims at the same time the Claimant requests and expedited internal appeal of an urgent claim.
An expedited review may be requested if the Claimant's condition, without immediate medical attention, could result in serious jeopardy to the Claimant's life or health or the Claimant's

ability to regain maximum function; or the Claimant has received a final internal appeal denial concerning admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

If the Claimant's request for external review is complete and the Claimant is eligible for external review, an IRO will conduct the review. The IRO will issue a decision within 72 hours after the IRO receives the request for external review. If the decision is not in writing, within 48 hours after providing that notice, the IRO will provide a written confirmation. This decision will include the main reasons for the decision, including the rationale for the decision.

If the IRO grants the appeal, then the IRO's decision is final and binding. However, if the IRO denies the appeal, a voluntary appeal is available whereby the Claimant may then appeal any such adverse determination to the Fund's Board of Trustees as described below.

Appeals to the Plan's third-party administrator should be addressed as follows:

Anthem Blue Cross and Blue Shield
Attn: Appeals
P.O. Box 105568
Atlanta, GA 30348-5568

Effective July 12, 2019, the initial eligibility rules shall be clarified in the Section entitled, **Eligibility Requirements**:

Active Participants

Initial Eligibility

You become eligible for coverage under the Plan if you:

1. Perform work that is under the jurisdiction of an Iron Workers Local Union that participates in the Plan (i.e., Covered Employment); **and**
2. Complete at least 1,000 hours of work during a 12-consecutive calendar month period, with some hours worked in the first month of the 12-month period.

Active Participants are eligible for:
- Medical Benefits;
- Prescription Drug Benefits;
- Dental Benefits;
- Vision Benefits;
- Hearing Aid Benefits;
- Health Reimbursement Account (HRA);
- Weekly Income Benefits;
- Life Insurance Benefits; and
- Accidental Death and Dismemberment (AD&D) Insurance Benefits.

In order to receive benefits, the Benefit Trust Office must receive your completed enrollment card with your list of Dependents and your Beneficiary. Claims may be denied or payments may be delayed if you have not submitted your enrollment card to the Benefit Trust Office.

New Employees. New bargaining unit ironworkers to this District Council who have never had hours reported to this Plan including Apprentices, newly organized and, transfers from other district councils, generally are eligible for coverage after 500 hours of work in Covered Employment during a five-consecutive month period, provided some hours are worked in the first month of the five-month period.

When Coverage Begins

Coverage begins on the first day of the second month after you meet the eligibility requirements, which is your Effective Date for benefits. If you are not actively at work due to disability when coverage begins, eligibility for Weekly Income Benefits will not begin until you return to active employment.

If you are an Active Participant, you should have all of your pay stubs in case you have to verify eligibility for benefits.

Example

Chris is an apprentice who begins work on January 1, 2020 and completes 500 hours of work in Covered Employment prior to June 1, 2020 (worked 500 hours during consecutive 5-month period). He will be eligible for benefit coverage beginning July 1, 2020 (the first day of the second month after satisfying hours' requirement).

Attachment 1

Active Participants and Dependents
Schedule of Benefits

Medical Benefits	Network Coverage	Non-Network Coverage
Calendar Year Deductible	$500 per person; $1,000 per family	$1,000 per person; $2,000 per family
Calendar Year Out-Of-Pocket Maximum	$4,000 per person; $8,000 per family	$8,000 per person; $16,000 per family
Preventive Care / Immunizations	You pay $0 Copayment	You pay 30% Coinsurance
Prescription Drug Benefits	**Network Pharmacy**	**Non-Network Pharmacy**
Deductible (combined network and non-network Pharmacy)	$65	
Retail Pharmacy Maximum Supply: 30 days Copayment: Generic Brand Formulary Brand Non-Formulary Specialty	 Per prescription: You pay $10 You pay $40 You pay $60 You pay $60	 You pay 50%; minimum $55 You pay 50%; minimum $55 You pay 50%; minimum $55 You pay 50%; minimum $55
Mail-Order Maximum Supply: 90 days Copayment: Generic Brand Formulary Brand Non-Formulary Specialty	 Per prescription: You pay $20 You pay $60 You pay $90 You pay $90	Not covered
Calendar Year Out-Of-Pocket Maximum	$4,150 per person; $8,300 per family	Unlimited

Plan A Non-Medicare Eligible Retirees and Dependents
Schedule of Benefits

Medical Benefits	Network Coverage	Non-Network Coverage
Calendar Year Deductible	$400 per person; $1,000 per family	$700 per person; $1,800 per family
Calendar Year Out-Of-Pocket Maximum	$3,250 per person; $6,500 per family	$6,000 per person; $12,000 per family
Preventive Care / Immunizations	You pay $0 Copayment	You pay 40% Coinsurance
Prescription Drug Benefits	**Network Pharmacy**	**Non-Network Pharmacy**
Deductible (combined network and non-network Pharmacy)	$50	
Retail Pharmacy Maximum Supply: 30 days Copayment: Generic Brand Formulary Brand Non-Formulary Specialty	 Per prescription: You pay $10 You pay $25 You pay $40 You pay $40	 You pay 50%; minimum $40 You pay 50%; minimum $40 You pay 50%; minimum $40 You pay 50%; minimum $40
Mail-Order Maximum Supply: 90 days Copayment: Generic Brand Formulary Brand Non-Formulary Specialty	 Per prescription: You pay $20 You pay $50 You pay $80 You pay $80	Not covered
Calendar Year Out-Of-Pocket Maximum	$4,900 per person; $9,800 per family	Unlimited

Plan B Non-Medicare Eligible Retirees and Dependents
Schedule of Benefits

Medical Benefits	Network Coverage	Non-Network Coverage
Calendar Year Deductible	$1,000 per person; $2,000 per family	$2,000 per person; $4,000 per family
Calendar Year Out-Of-Pocket Maximum	$5,250 per person; $10,500 per family	$10,500 per person; $21,000 per family
Preventive Care / Immunizations	You pay $0 Copayment	You pay 50% Coinsurance
Prescription Drug Benefits	**Network Pharmacy**	**Non-Network Pharmacy**
Deductible (combined network and non-network Pharmacy)	$200	
Retail Pharmacy Maximum Supply: 30 days Copayment: Generic Brand Formulary Brand Non-Formulary Specialty	 Per prescription: You pay $10 You pay $30 50%; min $50/$100 max 50%; min $50/$100 max	 You pay 50%; minimum $50 You pay 50%; minimum $50 You pay 50%; minimum $50 You pay 50%; minimum $50
Mail-Order Maximum Supply: 90 days Copayment: Generic Brand Formulary Brand Non-Formulary Specialty	 Per prescription: You pay $20 You pay $70 You pay $125 You pay $125	Not covered
Calendar Year Out-Of-Pocket Maximum	$2,900 per person; $5,800 per family	Unlimited

AMENDMENT NO. 11

TO THE IRON WORKERS DISTRICT COUNCIL OF SOUTHERN OHIO AND VICINITY BENEFIT TRUST PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

[February 1, 2015 Edition]

WHEREAS, the Board of Trustees ("Trustees") of Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust and its resulting Plan ("Plan") previously adopted an Agreement and Declaration of Trust ("Trust"), as amended and restated from time to time, and currently administers and maintains the Plan for the sole and exclusive benefit of those Participants and Beneficiaries covered thereunder; and

WHEREAS, in accordance with those documents, the Plan may be amended from time to time by the Trustees; and

WHEREAS, the Trustees desire to amend the Plan in response to new model notices issued on May 1, 2020 by the U.S. Department of Labor ("DOL") regarding the Consolidated Omnibus Budget Reconciliation Act ("COBRA").

NOW THEREFORE, BE IT RESOLVED BY THE TRUSTEES, that the Plan (and Summary Plan Description), shall be amended effective May 1, 2020 as follows:

Replace the section entitled **COBRA Continuation Coverage,** beginning on page 15 of the Plan Document and Summary Plan Description, with the following new model notice language:

COBRA Continuation Coverage

Introduction

This section has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Fund. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Fund and under federal law, you should review the remainder of the Fund's Summary Plan Description or contact the Fund Office.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance

Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Fund coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Fund is lost because of the qualifying event. Under the Fund, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're a participant, you'll become a qualified beneficiary if you lose your coverage under the Fund because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of a participant, you'll become a qualified beneficiary if you lose your coverage under the Fund because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Fund because of the following qualifying events:

- The parent-participant dies;
- The parent-participant's hours of employment are reduced;
- The parent-participant's employment ends for any reason other than his or her gross misconduct;
- The parent-participant becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Fund as a "dependent child."

When is COBRA continuation coverage available?

The Fund will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Administrator has been notified that a qualifying event has occurred. The employer must notify the Fund Office of the following qualifying events:

- The end of employment or reduction of hours of employment;

- Death of the participant; or
- The participant's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the participant and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Fund Office within 60 days after the qualifying event occurs. You must provide this notice to: Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust, Attention: COBRA, 1470 Worldwide Place, Vandalia, OH 45377-1156.

How is COBRA continuation coverage provided?

Once the Fund Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered participants may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Fund is determined by Social Security to be disabled and you notify the Fund Office in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Fund is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the participant or former participant dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Fund as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Fund had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my Fund coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Fund may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning the Fund or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

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[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

Keep your Fund informed of address changes

To protect your family's rights, let the Fund Office know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust
Attention: COBRA
1470 Worldwide Place
Vandalia, OH 45377-1156
Telephone Number: (800) 331-4277

AMENDMENT NO. 12

TO THE IRON WORKERS DISTRICT COUNCIL OF SOUTHERN OHIO AND VICINITY BENEFIT TRUST PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

[February 1, 2015 Edition]

WHEREAS, the Board of Trustees ("Trustees") of Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust and its resulting Plan ("Plan") previously adopted an Agreement and Declaration of Trust ("Trust"), as amended and restated from time to time, and currently administers and maintains the Plan for the sole and exclusive benefit of those Participants and Beneficiaries covered thereunder; and

WHEREAS, in accordance with those documents, the Plan may be amended from time to time by the Trustees; and

WHEREAS, the Trustees desire to amend the Plan as follows:

1. To waive Participant cost sharing for COVID-19 testing to comply with the Families First Coronavirus Response Act of 2020;

2. To waive the Participant co-pay for LiveHealth Online program effective March 18, 2020 through the end of the National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak; and

3. To waive the Participant co-pay for telehealth and virtual office visits effective March 18, 2020 through the end of the National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak.

NOW THEREFORE, BE IT RESOLVED BY THE TRUSTEES, that the Plan (and Summary Plan Description), shall be amended effective on the dates set forth below, as follows:

- Effective March 18, 2020, through the end of the National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak, the section entitled **Schedule of Benefits** shall be amended to waive cost sharing for the following services:
    - Diagnostic tests to detect the virus that causes COVID-19 that are approved or authorized by the FDA, including the administration of such tests; and
    - Items and services furnished to individuals during provider office visits (whether in-person or via telehealth), urgent care visits, and emergency room visits that result in an order for, or the administration of, the test described above, but only to the extent such items or services relate to the furnishing or administration of the test or the evaluation of whether the person needs the test.

- Effective March 18, 2020, through the end of the National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak, the section entitled **Schedule of Benefits** shall be amended to waive the Participant co-pay for LiveHealth Online.

- Effective March 18, 2020, through the end of the National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak, the section entitled **Schedule of Benefits** shall be amended to waive the Participant co-pay for telehealth and virtual office visits.

AMENDMENT NO. 13

TO THE IRON WORKERS DISTRICT COUNCIL OF SOUTHERN OHIO AND VICINITY BENEFIT TRUST PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

[February 1, 2015 Edition]

WHEREAS, the Board of Trustees ("Trustees") of Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust and its resulting Plan ("Plan") previously adopted an Agreement and Declaration of Trust ("Trust"), as amended and restated from time to time, and currently administers and maintains the Plan for the sole and exclusive benefit of those Participants and Beneficiaries covered thereunder; and

WHEREAS, in accordance with those documents, the Plan may be amended from time to time by the Trustees;

WHEREAS, on January 31, 2020, pursuant to section 319 of the Public Health Services Act, the Secretary of Health and Human Services issued a Determination That a Public Health Emergency Exists regarding the 2019 Novel Coronavirus (COVID-19) ("Public Health Emergency"); and

WHEREAS, the Trustees desire to amend the Plan to waive Participant cost-sharing for COVID-19 vaccination.

NOW THEREFORE, BE IT RESOLVED BY THE TRUSTEES, that the Plan (and Summary Plan Description) shall be amended effective on the dates set forth below, as follows:

- The sections entitled **Medical Benefits (For Active Participants, Non-Medicare Eligible Retirees, and Dependents),** **Covered Medical Expenses (For Active Participants, Non-Medicare Eligible Retirees, and Dependents),** and **Prescription Drug Benefits (For Active Participants, Non-Medicare Eligible Reitrees, and Dependents)** shall be amended as follows:

    - Effective December 26, 2020 through the end of the Public Health Emergency, the Plan will waive cost-sharing for any FDA-authorized COVID-19 vaccine, including the administration of any such vaccine by a Network or Non-Network Provider. The Plan will pay Non-Network Providers in an amount that is reasonable, as determined in comparison to prevailing market rates for such service.

    - Effective after the Public Health Emergency ends, the Plan will cover any FDA-authorized COVID-19 vaccination as a Preventive Service.

- The section entitled **Medical and Prescription Drug Benefits (For Medicare-Eligible Retirees and Dependents)** shall be amended as follows:

    - Effective for the duration of the Public Health Emergency, the Centers for Medicare & Medicaid Services (CMS) will cover, without Participant cost-sharing, any FDA-authorized COVID-19 vaccine, including the administration of any such vaccine.

AMENDMENT NO. 14

TO THE IRON WORKERS DISTRICT COUNCIL OF SOUTHERN OHIO AND VICINITY BENEFIT TRUST PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

[February 1, 2015 Edition]

WHEREAS, the Board of Trustees ("Trustees") of Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust and its resulting Plan ("Plan") previously adopted an Agreement and Declaration of Trust ("Trust"), as amended and restated from time to time, and currently administers and maintains the Plan for the sole and exclusive benefit of those Participants and Beneficiaries covered thereunder; and

WHEREAS, in accordance with those documents, the Plan may be amended from time to time by the Trustees;

WHEREAS, the Trustees desire to amend the Plan to reflect that they have entered into an agreement with VSP for it to become the Plan's vision plan provider.

NOW THEREFORE, BE IT RESOLVED BY THE TRUSTEES, that the Plan (and Summary Plan Description) shall be amended effective January 1, 2021, as follows:

The section entitled **Vision Benefits (For Active Participants and Dependents)** shall be amended as follows:

- Replace the first paragraph with the following:

> Vision coverage provides Active Participants and eligible Dependents with coverage for routine vision related expenses. Effective January 1, 2021, VSP is the Plan's vision plan provider, and the VSP Choice Plan is the vision network. By choosing an In-Network Vision Provider, you pay only your co-pay (if applicable), or the amount that exceeds your benefit allowance at the point of service. You can find participating Vision Providers online at www.vsp.com/choicewithaffiliates, or by calling VSP's Customer Service department at 800-877-7195 from Monday through Friday from 8:00 a.m. to 11:00 p.m. Eastern Time (ET) and Saturday and Sunday from 10:00 a.m. to 11:00 p.m. ET.

After January 1, 2021, you can review your eligibility status, claims paid information, and covered benefits by visiting www.vsp.com or by using the VSP app, and logging into your personalized account. Once logged in, you'll see personalized benefit information, including doctor visits, benefits history, how to use your benefits, and how to find a provider.

- Replace the first sentence of the subsection entitled **Vision Covered Expenses** with the following:

> **Vision Covered Expenses**
>
> All vision services including your eye exam and vision materials provided on and after January 1, 2021 will be processed by VSP. See the applicable *Schedule of Benefits* insert to this booklet for more information on your vision coverage.

- Replace the second box in its entirety and replace it with the following:

> *In-Network Benefits:*
> The Choice Plan network plus affiliates includes providers such as Wisconsin Vision, Pearle Vision, Wal-Mart, Sam's Club, Costco, Eye-Mart, Visionworks, Clarkson Eyecare, Wing Eyecare, Midwest Eye Consultants, plus thousands of independent optometrists and ophthalmologists. By choosing an In-Network Provider, you pay only your co-pay (if applicable), or the amount that exceeded your benefit allowance at the point of service. There are no claims for you to file for reimbursement from your VSP plan.

The section entitled **How to File Claims and Appeals** shall be amended as follows:

- The subsection entitled **Dental, Vision, Hearing Aid, and Weekly Income Benefit Claims** shall be amended to eliminate each instance of "Vision".

- A new subsection entitled **Vision Benefit Claims** shall be added immediately following the subsection entitled **Dental, Hearing Aid, and Weekly Income Benefit Claims** as follows:

> ***Vision Benefit Claims***
>
> In-Network Vision Providers and many Non-Network Vision Providers will submit claims on your behalf. If you use a Non-Network Vision Provider who does not submit a claim on your behalf and requires you to pay the Provider directly, submit a claim to VSP for reimbursement, using the following procedures:
>
> - Complete VSP's **Member Reimbursement Form** which can be found at vsp.com or at iwtrustfund.com/forms.
> - Submit your completed claim form along with your itemized receipt online at vsp.com or by mail to:
>
> VSP
> P.O. Box 385018
> Birmingham, AL 35238-5018.

The subsection entitled **Insurance Companies/Vendors** in the section entitled **Important Information About the Plan** shall be amended as follows:

Insurance Companies/Vendors

Vision benefits (Active and Non-Medicare) are processed by:

VSP
P.O. Box 385018
Birmingham, AL 35238-5018

Customer Service: 800-877-7195

[All other benefits are provided on a self-funded basis and processed directly from the Benefit Trust Plan.]

The section entitled **Contact Information** shall be amended as follows:

▪ If You Need Information About …	▪ Contact …
▪ Insurance Eligibility ▪ Dependent Eligibility ▪ Dental Benefits ▪ Hearing Aid Benefits ▪ Weekly Income Benefits ▪ Life Insurance Benefits ▪ Accidental Death and Dismemberment (AD&D) Insurance Benefits	Benefit Trust Office 1470 Worldwide Place Vandalia, OH 45377-1156 Phone: (937) 454-1744 Fax: (937) 454-5457 Web: iwtrustfund.com
▪ Vision Benefits	VSP Vision Care Claims Address: P.O. Box 385018 Birmingham, AL 35238 Customer Service: (800) 877-7195 www.vsp.com

The subsection entitled **Active Participants and Dependents Schedule of Benefits** in the section entitled **Schedule of Benefits** shall be amended as follows:

Active Participants and Dependents Schedule of Benefits

Vision Benefits	**VSP Choice Plan**		
	In-Network		**Out-of-Network**
Frequency for Exams, Lenses, Frames, Contact Lenses	Once every 12 months: Benefits start over every January 1st		
Exam Copay	$0		$45
Lens Copays:			
Single Vision	$0		$30
Bifocal	$0		$50
Trifocal	$0		$65
Frame Allowance	$200 allowance, then 20% off any balance		$70 Allowance
Enhanced Feature Frame*	$250 allowance, then $20% off any balance		$70 Allowance
Contact Lens Fitting & Evaluation Allowance	$50 allowance		No Coverage
Contact Lenses	$200 allowance (instead of frames and lenses)		$105 allowance (instead of frames and lenses)
Lens Enhancement Copays:	**Single Vision**	**Bi-Focal or Tri-Focal**	**Out-of-Network**
Standard Anti Reflective Coating	$41	$41	No Coverage
UV Protection	$10	$10	No Coverage
Polycarbonate Lenses (Child)	$0	$0	No Coverage
Polycarbonate Lenses (Adult)	$31	$35	No Coverage
Photochromic Lenses	$75	$75	No Coverage
Progressive Lenses			

Standard Progressive Lenses	N/A	$0	No Coverage
Premium Progressive Lenses**	N/A	$95 or $105	No Coverage
Custom Progressive Lenses**	N/A	$150 or $175	No Coverage
Scratch Resistant Coating	$17	$17	No Coverage

Enhanced Feature Frame: When using VSP providers in the "Premier Program"

*****Progressive Lens copays vary based upon the lens manufacturer and retail cost.***

AMENDMENT NO. 15

TO THE IRON WORKERS DISTRICT COUNCIL OF SOUTHERN OHIO AND VICINITY BENEFIT TRUST PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

[February 1, 2015 Edition]

WHEREAS, the Board of Trustees ("Trustees") of Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust and its resulting Plan ("Plan") previously adopted an Agreement and Declaration of Trust ("Trust"), as amended and restated from time to time, and currently administers and maintains the Plan for the sole and exclusive benefit of those Participants and Beneficiaries covered thereunder; and

WHEREAS, in accordance with those documents, the Plan may be amended from time to time by the Trustees;

WHEREAS, the Trustees desire to amend the Plan to reflect that the Trustees have entered an agreement with PrudentRx to provide specialty medication copay assistance to Active Participants, Non-Medicare Eligible Retirees, and their Dependents.

NOW THEREFORE, BE IT RESOLVED BY THE TRUSTEES, that the Plan (and Summary Plan Description) shall be amended effective **August 1, 2021**, as follows:

The section entitled **Prescription Drug Benefits (For Active Participants, Non-Medicare Eligible Retirees, and Dependents)** shall be amended to add the following subsection:

PrudentRx Copay Program for Specialty Medications

In order to provide a comprehensive and cost-effective prescription drug program for you and your family, the Benefit Trust has contracted with PrudentRx to offer the PrudentRx Copay Program for certain specialty medications. The PrudentRx Copay Program assists participants and dependents by helping them enroll in manufacturer copay assistance programs. Medications in the specialty tier will be subject to a 30% co-insurance. However, enrolled participants and dependents who get a copay card for their specialty medication (if applicable), will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Copay Program.

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications - in particular, specialty medications. The PrudentRx Copay Program will assist participants and dependents in obtaining copay assistance from drug manufacturers to reduce the cost share for eligible medications thereby reducing out-of-pocket expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs, but please be assured that this is done in compliance with HIPAA.

If you currently take one or more medications included in the PrudentRx Program Drug List, you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication. All eligible participants and dependents are enrolled in the PrudentRx program via an easy two-step process: 1) The first step of enrollment is already complete as your member information is on file with PrudentRx and 2) You need to call PrudentRx at 1-800-578-4403 within the next 5 days to register for any copay assistance available from drug manufacturers. You can choose to opt out of the program and you must call 1-800-578-4403 to opt-out. Some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications – in that case, you must speak to someone at PrudentRx at 1-800-578-4403 to provide any additional information needed to enroll in the copay program. PrudentRx will also contact you if you are required to enroll in the copay assistance for any medication that you take. If you do not return their call, choose to opt-out of the program, or if you do not affirmatively enroll in any copay assistance as required by a manufacturer you will be responsible for the full amount of the 30% co-insurance on specialty medications that are eligible for the PrudentRx program.

If you or a covered family member are not currently taking, but will start a new medication covered under the PrudentRx Copay Program, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx program. PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Copay Program.

The PrudentRx Program Drug List may be updated periodically by the Plan.

Copayments for these medications, whether made by you, your plan, or a manufacturer’s copay assistance program, will not count toward your plan deductible.

Because certain specialty medications do not qualify as “essential health benefits” under the Affordable Care Act, the cost share payments for these medications, whether made by you or a manufacturer copayment assistance program, do not count towards the Plan’s out-of-pocket

maximum. A list of specialty medications that are not considered to be "essential health benefits" is available. An exception process is available for determining whether a medication that is not an essential health benefit is medically necessary for a particular individual.

PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Copay Program.

AMENDMENT NO. 16
TO THE IRON WORKERS DISTRICT COUNCIL OF SOUTHERN OHIO AND VICINITY

BENEFIT TRUST PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

[February 1, 2015 Edition]

WHEREAS, the Board of Trustees ("Trustees") of Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust and its resulting Plan ("Plan") previously adopted an Agreement and Declaration of Trust ("Trust"), as amended and restated from time to time, and currently administers and maintains the Plan for the sole and exclusive benefit of those Participants and Beneficiaries covered thereunder; and

WHEREAS, in accordance with those documents, the Plan may be amended from time to time by the Trustees;

WHEREAS, under the American Rescue Plan Act ("ARPA"), certain eligible individuals could receive a subsidy for COBRA continuation of coverage for the limited period of April 1, 2021 through September 30, 2021 (referred to as "ARPA COBRA");

WHEREAS, certain eligible Participants under the Plan elected ARPA COBRA for all or part of the period of April 1, 2021 through September 30, 2021;

WHEREAS, under the Plan's rules for the Health Reimbursement Account ("HRA"), if a Participant elects COBRA, this results in the forfeiture of that person's HRA when his coverage as an Active Participant ends (referred to as the "HRA Forfeiture Rule"); and

WHEREAS, in an effort not to penalize those individuals who elected ARPA COBRA, the Trustees desire to amend the Plan to allow for a limited exception to HRA Forfeiture Rule in the case of those Participants who elected ARPA COBRA.

NOW THEREFORE, BE IT RESOLVED BY THE TRUSTEES, that the Plan (and Summary Plan Description) shall be amended effective **November 9, 2021**, as follows:

The section entitled **Health Reimbursement Account (HRA)**, at subsection entitled **Using Your HRA**, shall be amended as follows:

Using Your HRA

As an Active Participant, you may use the balance in your HRA to pay for eligible health care expenses, as described in the following section. You may also use the balance to continue Active coverage for yourself and your Dependents through self-payments.

If you retire after January 1, 2008 and have a balance in your HRA from contributions made while you were an Active Participant, you are entitled to use the balance in your HRA to pay your Retiree coverage premiums or receive reimbursement for eligible health care expenses, as described in the following section.

Once you lose your eligibility and are no longer covered under the Plan, you may continue to use the money in your HRA to pay for previously eligible expenses for up to 18 months or until the money runs out, whichever comes first. The previously eligible expenses must have been submitted within 12 months of the date of service. If you still have a balance in your HRA after 18 months, you will forfeit any remaining balance. The forfeited balance cannot be restored under any circumstances.

In the event of your death, your surviving eligible spouse or surviving eligible Dependents will be given the same opportunity to receive reimbursement for out of pocket medical expenses or pay Retiree premiums that you had as an Active Participant or Retiree. Once they are no longer covered under the Plan, they may continue to use the money in the HRA to pay for eligible expenses for up to 18 months or until the money runs out, whichever comes first as stated above. If there is still a balance in the HRA after 18 months, it will be forfeited. The forfeited balance cannot be restored under any circumstances.

You cannot use the balance in your HRA to pay your COBRA Continuation Coverage premiums. If you elect to continue coverage under COBRA, you will forfeit the balance remaining in your HRA at the time your coverage as an Active Participant ends. Limited Exception: Under the American Rescue Plan Act ("ARPA"), certain eligible individuals could receive a subsidy for COBRA continuation of coverage for the limited period of April 1, 2021 through September 30, 2021 (referred to as "ARPA COBRA"). If you were a Plan Participant who elected ARPA COBRA, that election will not by itself result in the forfeiture of your HRA under this Plan.

You will also forfeit your HRA balance if your eligibility under the Plan is terminated for failure to follow the Rules and Regulations, including working for a non-union employer in the geographic area covered by the Plan.

Any unused balanced in your HRA at the end of a calendar year will be carried over into the next year. The unused balance can be carried over year after year until it is used or forfeited.

Your HRA has no cash value and cannot be cashed out at any time.

AMENDMENT NO. 17

TO THE IRON WORKERS DISTRICT COUNCIL OF SOUTHERN OHIO AND VICINITY BENEFIT TRUST PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

[February 1, 2015 Edition]

WHEREAS, the Board of Trustees ("Trustees") of Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust and its resulting Plan ("Plan") previously adopted an Agreement and Declaration of Trust ("Trust"), as amended and restated from time to time, and currently administers and maintains the Plan for the sole and exclusive benefit of those Participants and Beneficiaries covered thereunder; and

WHEREAS, in accordance with those documents, the Plan may be amended from time to time by the Trustees;

WHEREAS, under the American Rescue Plan Act ("ARPA"), certain eligible individuals could receive a subsidy for COBRA continuation of coverage for the limited period of April 1, 2021 through September 30, 2021 (referred to as "ARPA COBRA");

WHEREAS, certain eligible Participants under the Plan elected ARPA COBRA for all or part of the period of April 1, 2021 through September 30, 2021;

WHEREAS, under the Plan's self-payment rules ("Self-Pay"), if a Participant elects COBRA, this results in the forfeiture of that person's option to Self-Pay when his coverage as an Active Participant ends (referred to as the "Self-Pay Forfeiture Rule"); and

WHEREAS, in an effort not to penalize those individuals who elected ARPA COBRA, the Trustees desire to amend the Plan to allow for a limited, up to 9-month, exception to the Self-Pay Forfeiture Rule in the case of those Participants who elected ARPA COBRA.

NOW THEREFORE, BE IT RESOLVED BY THE TRUSTEES, that the Plan (and Summary Plan Description) shall be amended effective **May 11, 2021**, as follows:

The section entitled **Self-Payments**, shall be amended as follows:

Self-Payments

If your eligibility ends because you have not worked the required number of hours, you may also continue your eligibility for coverage by making monthly self-payments for yourself and your Dependents. You have two options to continue coverage, which include:

- Making self-payments for self-payment Continuation Coverage for up to 9 consecutive months; or

- Electing to make COBRA Continuation Coverage self-payments (please see the *COBRA Continuation Coverage* section*)*.

Regular self-payments will continue all of your benefits, except Dental, Vision, and Weekly Income Benefits. You must elect to make regular self-payments **in writing within 25 days following the date you would otherwise lose your eligibility. The self-payment is due in the Benefit Trust Office before the first day of each month for which eligibility is continued.** If you fail to make a self-payment it cannot be made up. Coverage will terminate at the end of the previously paid month.

A self-payment also continues coverage for your eligible Dependents who were covered under the Plan on the day your eligibility ended.

Self-payment Continuation Coverage ends on the earlier of:

- The last day of the month for which you have made 9 months of self-payments;
- The date you again qualify for coverage under the Plan by working for a Contributing Employer;
- The last day of the month preceding the month you do not make a required self-payment; or
- The date the Plan is terminated.

Your Dependents' coverage will also end on the date your coverage ends.

Limited Exception: Under the American Rescue Plan Act ("ARPA"), certain eligible individuals could receive a subsidy for COBRA continuation of coverage for the limited period of April 1, 2021 through September 30, 2021 (referred to as "ARPA COBRA"). If you were a Plan Participant who elected ARPA COBRA, that election will not by itself result in the termination of the self-payment option under this Plan. In such case, you will have the option to self-pay for up to nine (9) months in total, subtracting any months you self-paid immediately prior to taking the ARPA COBRA.

Example 1: Participant injured on the job June 2020. Active health insurance terminated April 30, 2021. Participant is ARPA COBRA subsidy eligible for May through September 2021 (5 months). On October 1 he can self-pay up to 9 months.

Example 2: Participant self-paid January 2021 through March 2021 (i.e., 3 months). He became ARPA COBRA subsidy eligible April 1 through September. On October 1 he can resume his self-pay for an additional 6 months.

AMENDMENT NO. 18

TO THE IRON WORKERS DISTRICT COUNCIL OF SOUTHERN OHIO AND VICINITY BENEFIT TRUST PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

[February 1, 2015 Edition]

WHEREAS, the Board of Trustees ("Trustees") of Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust and its resulting Plan ("Plan") previously adopted an Agreement and Declaration of Trust ("Trust"), as amended and restated from time to time, and currently administers and maintains the Plan for the sole and exclusive benefit of those Participants and Beneficiaries covered thereunder; and

WHEREAS, in accordance with those documents, the Plan may be amended from time to time by the Trustees; and

WHEREAS, under the No Surprises Act ("No Surprises"), effective for Plan Years on and after January 1, 2022, Plan Participants and Dependents are protected from charges in excess of the Plan's in-network cost-sharing amount (such as copayments and coinsurance) for emergency services, non-emergency care from out-of-network providers at in-network facilities, and air ambulance services from out-of-network providers.

NOW THEREFORE, BE IT RESOLVED BY THE TRUSTEES, that the Plan (and Summary Plan Description) shall be amended effective **February 1, 2022** (unless otherwise specified), as follows:

I. Network Cost Sharing for Non-Network Services

You may only be responsible for Network Cost Sharing for certain services, even if a Non-Network Provider provided those services.

"**Network Cost Sharing**" means:

- The amount you pay out-of-pocket (including amounts paid toward the Deductible, Coinsurance payments, and Copayments) will not be more than it would be if a Network Provider provided the services. In addition, the Plan will apply the amount you pay for the services to your Network Deductible and Network Out-of-Pocket Maximum in the same manner it would apply the amount you would have paid if a Network Provider provided those services.

II. Surprise Billing Situations

You will only be responsible for Network Cost Sharing for Surprise Billing Situations.

"**Surprise Billing Situation**" refers to:

- Non-Network Emergency Care;

- Non-Network air ambulance services; and
- Non-Network Non-Emergency Care at a Network Facility where there is no "Notice and Consent".

"**Emergency Care**" means:

- Services in an emergency department of a hospital or an independent freestanding emergency department as well as post-stabilization services in certain instances. The Plan will not require prior authorization for Emergency Care in an emergency department of a hospital or an independent freestanding emergency department.

"**Notice and Consent**" means that:

- 72 hours before providing the services, the Provider sent you (through postal mail or email) notice of its network status and an estimate of charges; and
- You consented in writing to receiving Non-Network services.

III. Continuing Care Patients

If, while you are a Network Provider's Continuing Care Patient, the Provider's Network status changes (for example, the Provider no longer participates in the Plan's Network), you will only be responsible for Network Cost Sharing for that Provider's services (if those services are related to the reason you are classified as a Continuing Care Patient) for the period ending on the earlier of:

- The 90-day period beginning on the date the Provider's network status changed; or
- The date on which you are no longer a Continuing Care Patient.

A "**Continuing Care Patient**" is, with respect to a Provider:

- Undergoing treatment for a Serious and Complex Condition;
- Undergoing institutional or inpatient care;
- Scheduled to undergo nonelective surgery, including postoperative care;
- Pregnant and undergoing pregnancy treatment; or
- Terminally ill (as defined by the Social Security Act) and receiving treatment for such illness.

A "**Serious and Complex Condition**" is:

- In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- In the case of a chronic illness or condition, a condition that—
    - Is life-threatening, degenerative, potentially disabling, or congenital; and
    - Requires specialized medical care over a prolonged period of time.

IV. Advanced Explanation of Benefits

After you schedule an appointment with a Provider, the Provider will provide the Plan with a good faith estimate of the expected charges for providing the scheduled item or service. After the Plan receives the estimate from your Provider, the Plan will provide you with an Advanced Explanation of Benefits within these time frames:

- If you schedule the appointment less than ten (10) business days before the scheduled item or service is to be furnished, then not later than one (1) business day after the Plan receives the estimate from your Provider; and
- If you schedule the appointment more than ten (10) business days before the scheduled item or service is to be furnished, then not later than three (3) days after the Plan receives the estimate from your Provider.

The Advanced Explanation of Benefits will state the following:

- Whether the Provider is In-Network, and:
    - If In-Network, the Plan's contracted rate for such item or service; and
    - If Non-Network, a description of how to obtain information on Network Providers;
- The good faith estimate that the Provider provided;
- Good faith estimates of:
    - The amount that the Plan will cover;
    - Your Cost Sharing amount; and
    - The amount you have incurred toward meeting the applicable Deductible and Out-of-Pocket Maximum as of the notification date;
- If applicable, a disclaimer that the item or service is subject to a medical management technique (for example, prior authorization or step-therapy); and
- A disclaimer that the information provided is an estimate and is subject to change.

AMENDMENT NO. 19

TO THE IRON WORKERS DISTRICT COUNCIL OF SOUTHERN OHIO AND VICINITY BENEFIT TRUST PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

[February 1, 2015 Edition]

WHEREAS, the Board of Trustees ("Trustees") of Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust and its resulting Plan ("Plan") previously adopted an Agreement and Declaration of Trust ("Trust"), as amended and restated from time to time, and currently administers and maintains the Plan for the sole and exclusive benefit of those Participants and Beneficiaries covered thereunder; and

WHEREAS, in accordance with those documents, the Plan may be amended from time to time by the Trustees.

NOW THEREFORE, BE IT RESOLVED BY THE TRUSTEES, that the Plan (and Summary Plan Description) shall be amended as follows:

Effective January 1, 2023

Plan A Non-Medicare Eligible Retirees and Dependents
Self-Payments

Calendar Year Self-Payment Incentive –

- If Retiree-only Coverage, the yearly Self-Payment is reduced by $500 in total, which savings is prorated over 12 months.
- If Retiree and Spouse Coverage, the yearly Self-Payment is reduced by $1,000 in total, which savings is prorated over 12 months.

All of the following conditions must be met:

(1) Retiree (and Spouse, if applicable) engages and visits his or her Primary Care Physician; and
(2) Retiree (and Spouse, if applicable) undergoes an annual in-person physical examination by or before October 31 of the calendar year and while covered under the Non-Medicare Plan.

Note:

- This incentive will be applied to the immediately following calendar year's self-payment. For example, to receive the incentive for the 2023 calendar year, you must engage and visit your Primary Care Physician and undergo an annual physical examination by October 31, 2022.

- If the Retiree and/or Spouse terminate coverage from the Non-Medicare Plan (which includes becoming eligible for Medicare during the calendar year), no further savings is passed on to the participant(s) who terminated coverage.

Plan B Non-Medicare Eligible Retirees and Dependents
Self-Payments

Calendar Year Self-Payment Incentive –

- If Retiree-only Coverage, the yearly Self-Payment is reduced by $500 in total, which savings is prorated over 12 months.
- If Retiree and Spouse Coverage, the yearly Self-Payment is reduced by $1,000 in total, which savings is prorated over 12 months.

All of the following conditions must be met:

(1) Retiree (and Spouse, if applicable) engages and visits his or her Primary Care Physician; and
(2) Retiree (and Spouse, if applicable) undergoes an annual in-person physical examination by or before October 31 of the calendar year and while covered under the Non-Medicare Plan.

Note:

- This incentive will be applied to the immediately following calendar year's self-payment. For example, to receive the incentive for the 2023 calendar year, you must engage and visit your Primary Care Physician and undergo an annual physical examination by October 31, 2022.
- If the Retiree and/or Spouse terminate coverage from the Non-Medicare Plan (which includes becoming eligible for Medicare during the calendar year), no further savings is passed on to the participant(s) who terminated coverage.

Effective for Disabilities on and after June 1, 2022

Article XI, Section A, Weekly Income Benefits (For Active Participants Only), is amended in part as follows:

When Benefits Begin

Your disability date will be determined from the date you were first treated by your Physician and the Physician certifies that you are totally disabled. In no event will your disability date be earlier than the date of the Physician visit.

Weekly Income Benefits will begin the:

- First full day of disability due to an accident, illness or sickness.

Successive periods of disability separated by less than one week of active full-time work are considered one period of disability unless the later disability is due to an injury or sickness entirely unrelated to the earlier disability and begins after you return to work full time.

Effective December 22, 2021 through the end of the COVID-19 Public Health Emergency

Section 10.08 Prescription Drug Benefits – add the following new provision:

COVID-19 Antiviral Therapy Program

Effective December 22, 2021 through the end of the COVID-19 Public Health Emergency, the Plan, through its prescription benefit manager CVS Caremark, will process and reimburse COVID-19 oral antiviral drug claims, whether at an in-network or out-of-network pharmacy. The ingredient cost is paid for by the federal government; the dispensing fee is paid for by the Plan. This includes a $10 dispensing fee to pharmacies, which replaces the normal network dispensing fee. Only oral antiviral therapies for COVID-19 that received Emergency Use Authorization from the FDA are covered. A quantity limit of one (1) course of therapy for each of the oral antiviral products within a 30-day window will be applied. An age limit will be applied as follows: 12+ for the Pfizer oral antiviral therapy and 18+ for the Merck oral antiviral therapy. Member cost-share will be set at $0.00.
