Amendment No. 8 to the 2020 Summary Plan Description and Plan Document of the NECA-IBEW Welfare Trust Fund

WHEREAS, the Board of Trustees of the NECA-IBEW Welfare Trust Fund ("Fund") may, pursuant to the terms of the Summary Plan Description and Plan Document ("SPD"), amend the SPD.

NOW, THEREFORE, the Trustees amend the 2020 SPD as follows subject to the conditions specified above. Page numbers refer to the numbering of the 2020 SPD:

1. *Effective January 1, 2024, the following section of the SPD before the Table of Contents is amended by deleting the Statement of Grandfathered Status.*

2. *Effective January 1, 2024, the "Plan Definitions" section of the SPD on page 5 shall be amended by adding a definition for "Approved Clinical Trials" as follows:*

   Approved Clinical Trials: An "Approved Clinical Trial" is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is:
   - Approved or funded by one of the following:
     (1) The National Institute of Health;
     (2) The Centers for Disease Control and Prevention;
     (3) The Agency for Health Care Research and Quality;
     (4) A cooperative group or center of any of the above entities or the Departments of Defense or Veterans Affairs;
     (5) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
     (6) The Departments of Veterans Affairs, Defense, or Energy if certain conditions are met.
   - Conducted under an investigational new drug application reviewed by the FDA; or
   - A drug trial that is exempt from having such an investigational new drug application

3. *Effective January 1, 2024, the "Plan Definitions" section of the SPD on page 6 shall be amended by adding a definition for Covered Person as follows:*

   Covered Person: A Covered Person is an individual eligible to receive benefits under the Plan.

4. *Effective January 1, 2024, the "Plan Definitions" section of the SPD on page 8 shall be amended by replacing Experimental and Investigational with the following statement:*

   Experimental and/or Investigational: The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as

"Experimental and/or Investigational." If your procedure is Experimental or Investigational, it may not be covered. If you are not sure if your procedure is Experimental or Investigational or if it is covered, you should call the Fund Office before you have the procedure to make sure that it will be covered.

Services mandated by the Affordable Care Act law for Approved Clinical Trials shall not be considered Experimental or Investigational. Approved Clinical Trials covered by the Plan include Phase I, II, III or IV trials that are conducted in relation to the prevention, detection or treatment of cancer or another life-threatening disease. The Plan reserves the right to use reasonable medical management techniques in interpreting and applying the coverage provisions related to Approved Clinical Trials;

A service or supply will be deemed to be Experimental and/or Investigational if, in the opinion of the Plan Administrator or its designee, based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for Pre-certification under the Plan, any of the following conditions were present with respect to one or more essential provisions of the service or supply:

1. The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the health care provider that performs the service or prescribes the supply;

2. The prescribed service or supply may be given only with the approval of an institutional Review Board as defined by federal law;

3. In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, dental, or scientific literature on the subject, or a preponderance of such literature published in the United States; and written by experts in the field; that shows that recognized medical, dental, or scientific experts: classify the service or supply as Experimental and/or Investigational; or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies;

4. With respect to services or supplies regulated by the Food and Drug administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current investigational new drug or new device application has been submitted and filed with the FDA. However, a drug will not be considered Experimental and/or Investigational if it is:

    a. Approved by the FDA as an "investigational new drug for treatment use"; or

b. Classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life threatening disease" as that term is defined in FDA regulations; or

c. Approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was not approved for general use, and the FDA has not determined that such drug should not be prescribed for a given type of cancer.

5. The prescribed service or supply is available to the Covered Person only through participation in a clinical trial that does not otherwise meet the definition of an Approved Clinical Trial.

   However, provided your participation in a clinical trial is for the prevention, detection, or treatment of cancer or other life-threatening condition or disease that is covered by the Plan then Routine Patient Costs related to participation in a clinical trial will not be considered experimental or investigational.

In determining if a service or supply is or should be classified as Experimental and/or Investigational, the Plan Administrator or its designee will rely only on the following specific information and resources that are available at the time the service or supply was performed, provided, or considered for Pre-certification under the Plan:

1. Medical or dental records of the Covered Person;

2. The consent document signed, or required to be signed, in order to receive the prescribed service or supply;

3. Protocols of the health care provider that renders the prescribed service or prescribes or dispenses the supply;

4. Authoritative peer-reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the Covered Person's diagnosis, including, but not limited to "United States Pharmacopeia Dispensing Information" and "American Hospital Formulary Service";

5. The published opinions of the American Medical Association (AMA), such as "The AMA Drug Evaluations" and "The Diagnostic and Therapeutic Technology Assessment (DATTA) Program," etc.; or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Center for Disease Control (CDC); or the Office of Technology Assessment; or the published screening criteria of national insurance companies such as Aetna and Cigna, or the American Dental Association (ADA), with respect to dental services or supplies;

6. Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply; and

7. The latest edition of "The Medicare Coverage Issues Manual."

5. *Effective January 1, 2024, the "Plan Definitions" section of the SPD on page 14 shall be amended by changing Out-of-Pocket Maximum to read as follows:*

Medical Coinsurance Out-of-Pocket Maximum: The maximum amount of Coinsurance each Covered Person or family is responsible for paying during a Calendar Year before the Coinsurance required by the Plan ceases to apply. When the Medical Coinsurance Out-of-Pocket Maximum is reached, the Plan will pay 100% of any additional covered expenses subject to Coinsurance provisions for the remainder of the Calendar Year. Coinsurance paid by a Covered Person or family member counts towards the Calendar Year Medical Out-of-Pocket Maximum.

Medical Out-of-Pocket Maximum: The portion of Covered Medical Expenses that you must pay per Calendar Year, including any applicable Medical Deductibles, Copayments, or Coinsurance before Covered Medical Expenses are paid at 100%. The Medical Out-of-Pocket Maximum does not include Covered Prescription Drug Out-of-Pocket Expenses, as those charges count toward the Prescription Drug Out-of-Pocket Maximum only. Please refer to the applicable schedule in the "Schedules of Benefits" document for more information about the Medical Out-of-Pocket Maximum.

Prescription Drug Out-of-Pocket Maximum: The portion of Covered Prescription Drug Expenses that you must pay per Calendar Year including any applicable Prescription Drug Deductibles, Copayments, or Coinsurance before Covered Prescription Drug Expenses are paid at 100%. The Prescription Drug Out-of-Pocket Maximum does not include Covered Medical Expenses, as those charges count toward the Prescription Drug Out-of-Pocket Maximum only. Please refer to the applicable schedule in the "Schedules of Benefits" document for more information about the Prescription Out-of-Pocket Maximum.

6. *Effective January 1, 2024, the "Plan Definitions" section of the SPD on page 16 shall be amended by adding a definition for Qualified Individual as follows:*

Qualified Individual: "Qualified Individual" is a Covered Person who is eligible, according to the trial protocol, to participate in an Approved Clinical Trial for the treatment of cancer or other life-threatening condition and either (1) the referring health care professional is a PPO provider and has concluded that the Covered Person's participation in the Approved Clinical Trial would be appropriate, or (2) the Covered Person provides medical and scientific information establishing that participation in the Approved Clinical Trial would be appropriate.

If one or more of the Plan's PPO providers is participating in an Approved Clinical Trial, the Plan may require the Qualified Individual to participate through such a PPO provider if the provider will accept the Qualified Individual as a participant in the trial. If a Qualified

Individual participates in an "Approved Clinical Trial," coverage under the Plan will be limited to "Routine Patient Costs".

7. *Effective January 1, 2024, the "Plan Definitions" section of the SPD on page 16 shall be amended by adding a definition for Routine Patient Costs as follows:*

   Routine Patient Costs: "Routine Patient Costs" include items and services typically provided under the Plan for a Covered Person not enrolled in an Approved Clinical Trial. However, such items and services do not include (i) the investigational item, device or service itself; (ii) items and services not included in the direct clinical management of the patient, but instead provided in connection with data collection and analysis; or (iii) a service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.

8. *Effective January 1, 2024, the Comprehensive Major Medical Benefit – Employees and Retirees Not Eligible for Medicare, and Their Dependents section of the SPD on page 53 shall be amended after the first paragraph by replacing the first four bulleted items with the following items:*

   • **Deductible:** You are responsible for meeting your Calendar Year Deductible (between January 1 and December 31) before the Plan begins to pay for Covered Medical Expenses. That means you and your Dependents must pay up to the amount of the Deductible (as shown in the applicable schedule in the "Schedules of Benefits" document) of Covered Medical Expenses before the Plan pays benefits. Once payments toward the individual Deductible for each of your family members reach the family maximum, individual Deductibles for all family members will be met for the year. The amounts you pay toward the annual Deductible will apply toward meeting the Plan's annual Medical Out-of-Pocket Maximum.

   • **Emergency Room Deductible:** If you or your Dependents visit a Hospital emergency room for treatment of a Sickness or Injury not due to an accident, you are required to pay an additional Deductible (as shown in the applicable schedule in the "Schedules of Benefits" document) for each visit after the first two visits in a Calendar Year. This Deductible is in addition to the Calendar Year Deductible and any other Coinsurance or Copayment amounts you are responsible for paying. In addition, this emergency room Deductible does not apply toward meeting your Calendar Year Deductible, but it will apply toward meeting your Medical Out-of-Pocket Maximum.

   • **Office Visit Copayment:** When you or a family member goes to a Physician's office, you pay a separate Copayment (as shown in the applicable schedule in the "Schedules of Benefits" document) for each office visit. This office visit Copayment is in addition to the Calendar Year Deductible and any other Coinsurance amounts you are responsible for paying. In addition, this office visit Copayment does not apply toward meeting your Calendar Year Deductible, but it will apply toward meeting your Medical Out-of-Pocket Maximum.

   • **Specialist Visit Copayment:** When you or a family member goes to a specialist's office, you pay a separate Copayment (as shown in the applicable schedule in the "Schedules of Benefits" document) for each office visit. This office visit Copayment is in addition to the Calendar Year Deductible and any other Coinsurance amounts you are responsible for paying.

In addition, this office visit Copayment does not apply toward meeting your Calendar Year Deductible, but it will apply toward meeting your Medical Out-of-Pocket Maximum.

9. *Effective January 1, 2024, the following section of the SPD on page 55 thereof is amended at the first two bullet points to read as follows:*

• Coinsurance: Once you or your Dependents meet the Deductible, the Plan pays a percentage of Covered Medical Expenses and you pay the rest. Benefits are paid based on Allowable Charges for the duration of an Injury or Sickness. The Coinsurance percentage the Plan pays varies depending on whether you use a PPO or non-PPO provider. If you or your Dependent uses a:

- **PPO provider**, the Plan pays a higher percentage of Allowable Charges, which requires you to pay the remaining percentage of Covered Medical Expenses, up to the Medical Coinsurance Out-of-Pocket Maximum (as shown in the applicable schedule in the "Schedules of Benefits" document); or
- **Non-PPO provider**, the Plan pays a lower percentage of Allowable Charges, which requires you to pay the remaining percentage of Covered Medical Expenses, up to the Medical Coinsurance Out-of-Pocket Maximum (as shown in the applicable schedule in the "Schedules of Benefits" document).

The Coinsurance percentages apply unless specifically noted otherwise.

• Medical Coinsurance Out-of-Pocket Maximum: The maximum amount of Coinsurance each Covered Person or family is responsible for paying during a Calendar Year before the Coinsurance required by the Plan ceases to apply. When the Medical Coinsurance Out-of-Pocket Maximum is reached, the Plan will pay 100% of any additional covered expenses subject to Coinsurance provisions for the remainder of the Calendar Year. Coinsurance paid by a Covered Person or family member counts towards the Calendar Year Medical Out-of-Pocket Maximum.

• Medical Out-of-Pocket Maximum: The portion of Covered Medical Expenses that you must pay per Calendar Year, including any applicable Medical Deductibles, Copayments, or Coinsurance before Covered Medical Expenses are paid at 100%. The Medical Out-of-Pocket Maximum does not include Covered Prescription Drug Expenses, as those charges count toward the Prescription Out-of-Pocket Maximum only. Please refer to the applicable schedule in the "Schedules of Benefits" document for more information about the Medical Out-of-Pocket Maximum.

• Prescription Drug Out-of-Pocket Maximum: The portion of Covered Prescription Drug Expenses that you must pay per Calendar Year, after you meet including any applicable Prescription Drug Deductibles, Copayments, or Coinsurance, before Covered Prescription Expenses are paid at 100%. The Prescription Out-of-Pocket Maximum does not include Covered Medical Expenses, as those charges count toward the Medical Out-of-Pocket Maximum only. Please refer to the applicable schedule in the "Schedules of Benefits" document for more information about the Prescription Drug Out-of-Pocket Maximum.

Note that some benefits and expenses may be covered differently or be subject to benefit maximums. See the applicable schedule in the "Schedules of Benefits" document and specific benefit descriptions for more information.

10. *Effective January 1, 2024, a new section shall be added to the SPD on page 64 after the list of Covered Medical Expenses to read as follows:*

Preventive Care Benefits:
Under the Affordable Care Act, the Fund is required to provide certain "preventive care" services without imposing any cost sharing requirements, meaning that no Deductibles, Copayments, Coinsurance, or Cost-Sharing with respect to the required preventive care services will be imposed. While the Fund may not impose Cost-Sharing with respect to services provided by PPO Providers, it is permitted to and may impose them with respect to Non-PPO providers.

A listing of covered preventive care services can be found on this website: https://www.healthcare.gov/coverage/preventive-care-benefits/. There are 3 sets of free preventive services. The links below will provide a list of covered services for each group:

- For all adults - https://www.healthcare.gov/preventive-care-adults/
- For women - https://www.healthcare.gov/preventive-care-women/
- For children - https://www.healthcare.gov/preventive-care-children/

***IMPORTANT NOTE**: The guidelines provide that some services are to be rendered without a Copayment only for certain individuals with identified risk factors.*

***IMPORTANT NOTE:** Due to Federal laws and guidelines, certain services that may sometimes be considered Preventive Care Benefits with no Cost-Sharing, may at other times be subject to applicable Plan Cost-Sharing due to frequency limitations on Preventive Care Benefits. Here are two examples of how this works:*

Example 1: A "preventive" colorectal cancer colonoscopy screening for adults aged 45-75 is covered as a Preventive Care Benefit with no Cost-Sharing once every ten years. However, a colorectal cancer colonoscopy screening which needs to be performed more frequently for diagnostic purposes due to certain diagnoses or other circumstances will be covered with applicable Plan Cost-Sharing.

Example 2: A "preventive" mammography screening for women aged 40-74 is covered as a Preventive Care Benefit with no Cost-Sharing once per year. However, a mammography screening which needs to be performed more frequently for diagnostic purposes due to certain diagnoses or other circumstances will be covered with applicable Plan Cost-Sharing.

A comprehensive list of all "preventive care" services covered as Preventive Care Benefits without Cost-Sharing, along with the applicable covered frequencies of each service, can be found under the Preventive Care section of the Fund's website: www.neca-ibew.org

11. *Effective January 1, 2024, the following section of the SPD on page 64 thereof is amended to read as follows:*

    Chiropractic Treatment: Treatment from a chiropractor in connection with the detection, treatment, and correction of structural imbalance, subluxation, or misalignment of the vertebral column to alleviate pressure on spinal nerves, including X-ray and laboratory charges. The Plan covers 50% of the Allowable Charges for up to 48 visits in a Calendar Year.

12. *Effective January 1, 2024, the section on Organ Transplants on page 67 shall be amended by replacing the section with the following:*

Organ Transplants: The Plan covers Organ Transplants. Pre-certification is required for Medical Necessity. Contact the Fund Office Utilization Review Department immediately regarding Organ Transplants. Benefits are provided according to the applicable schedule in the "Schedules of Benefits" document. Covered Organ Transplant surgeries are those defined as non-Experimental by the Centers for Medicare & Medicaid Services (CMS) for the condition being treated, including, but not limited to, kidney, bone marrow, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney transplants.

Organ procurement benefits are limited to a $20,000 maximum (payable at 100%, not subject to the Plan's Deductible) at non-Centers of Excellence facilities. There is no organ procurement benefit maximum at Centers of Excellence facilities (effective October 1, 2020). If you use a Centers of Excellence (COE) facility, the Plan's Coinsurance and Out-of-Pocket Maximums apply. If a COE facility is not used but the facility is a PPO provider, the Plan only pays 50% of the Allowable Charge, and the Medical Out-of-Pocket Maximum will apply. The Prescription Out-of-Pocket Maximum will also apply. However, if a COE facility is not used and the facility is a Non-PPO provider, the Plan only pays 50% of the Allowable Charge, and there is no Medical Out-of-Pocket Maximum or Prescription Out-of-Pocket Maximum on the amount of expenses you are required to pay.

The following services are included:

- The use of temporary mechanical equipment, pending the acquisition of "matched" human organ(s);
- Multiple Organ Transplant(s) during one operative session;
- Replacement(s) or subsequent Organ Transplant(s);
- Work-up and follow-up expenses; and
- Transportation and lodging expenses (effective October 1, 2020), limited to the Plan's per-transplant benefit period maximum shown in the applicable schedule in the "Schedules of Benefits" document, which include:
    - Transportation to and from the site of the covered Organ Transplant procedure for the Eligible individual and one other individual, or in the event the Eligible individual or

the donor is a minor, two other individuals. Transportation expenses include airfare, toll/parking fees, and tax and gas mileage at the standard IRS rate; and
- Reasonable and necessary lodging expenses, including apartment or hotel rental.

Donor expenses will include:

- Testing to identify suitable donor(s);
- The expense for the procurement of organ(s) from a donor;
- The expense of life support of a donor pending the removal of usable organ(s); and
- Transportation of organ(s) or a donor on life supports.

Expenses incurred by a non-Eligible donor to an Eligible Person will be paid under this Plan, provided such charges are not payable under another plan.

13. Effective January 1, 2024, the section Prescription Drug Benefit for Participants Not Eligible for Medicare beginning on pages 73-79 shall be amended to read as follows:

Prescription Drug Benefit for Participants Not Eligible for Medicare

NOTE: For information about prescription drug coverage for Eligible retirees and their Eligible Dependents who are Eligible for Medicare, please see the "Prescription Drug Benefit for Participants Eligible for Medicare" section on page 80.

Prescription Drug Benefits are available to all Eligible Persons. The Plan's Prescription Drug Benefit is administered through MedImpact. The Prescription Drug Benefit includes coverage for medications purchased at retail pharmacies or through the MedImpact mail service pharmacy program, subject to the prescription drug Deductible and any applicable Copayment or Coinsurance as outlined below and in the applicable schedule in the "Schedules of Benefits" document. The Fund's Prescription Drug Benefit also includes a Specialty Medication Program.

The retail pharmacy component provides access to a national network of participating retail pharmacies, which have agreed to provide medications at a discounted price for Eligible Participants. For a free listing of participating pharmacies, mail-order forms, and information regarding coverage for specific medications, contact MedImpact at the telephone number stated on your MedImpact prescription drug card or through its website, www.medimpact.com. For information about the Specialty Medication Program, visit www.medimpact.com.

Prescription Drug Calendar Year Deductible

The prescription drug Deductible for each Calendar Year with respect to each Eligible Person is shown on the applicable schedule in the "Schedules of Benefits" document.

Prescription Drug Out-of-Pocket Maximum

The portion of Covered Prescription Drug Expenses that you must pay per Calendar Year, after you meet any applicable Prescription Drug Deductibles, Copayments, or Coinsurance, before Covered Prescription Expenses are paid at 100%. The Prescription Out-of-Pocket Maximum does not include Covered Medical Expenses, as those charges count toward the Medical Out-of-Pocket Maximum only. Please refer to the applicable schedule in the "Schedules of Benefits" document for more information about the Prescription Drug Out-of-Pocket Maximum.

Formulary

The prescription drug plan utilizes a four-tier formulary. A formulary is a list of prescribed medications, including generic, brand name (preferred and non-preferred), and specialty medications, that have proven to be both clinically effective and cost effective. Prescription drugs on the formulary are categorized into four tiers, and these tiers determine your cost for a particular medication. There are preferred products in every therapeutic class in the formulary. Some medications are "excluded" from the formulary, and these medications are not covered under the prescription drug plan. **If you choose to fill a prescription for a medication that is not on the Plan's list of Covered Medications, you will pay 100% of the cost.** The formulary may change from time to time throughout the Calendar Year. Refer to www.medimpact.com for the current formulary.

Drug Tier	Definition
Generic	A drug that is equivalent to a brand name prescription. By law, a generic must contain the same active ingredients as brand name drugs. Therefore, taking a generic drug should treat the condition the same as the brand, but the prescription may be obtained at a lower cost.
Preferred Brand	Brand name medications that are on the formulary.
Non-Preferred Brand	Brand name medications that are placed at a higher cost share tier on the formulary.
Specialty	Medications used to treat complex conditions (e.g., rheumatoid arthritis, multiple sclerosis, cancer, etc.). This includes certain pharmaceuticals, biotech, or biological drugs that are used in the management of chronic or genetic disease, including, but not limited to, injectable, infused, or oral medications, or products that otherwise require special handling.

Retail Pharmacy Program

In addition to the prescription drug Deductible outlined above, you pay a Copayment or Coinsurance for each prescription filled under the Retail Pharmacy Program. When you have your prescription filled at a participating retail pharmacy, you will be charged the applicable Copayment set forth in the applicable schedule in the "Schedules of Benefits" document. If you

choose a non-preferred brand name medication when a generic substitute is available, you are required to pay the applicable Copayment as shown in the applicable schedule in the "Schedules of Benefits" document plus the difference in cost between the non-preferred brand name and the generic equivalent. You may obtain up to a 34-day supply at a retail pharmacy.

Maintenance medications are those medications that are taken for an extended period to treat a chronic condition, such as diabetes, high blood pressure, arthritis, or heart disease. The Retail Pharmacy Program will honor your initial maintenance medication prescription for 34 days or fewer and up to two refills. Following three prescriptions for up to 34 days, maintenance scripts must be filled for 90-day supplies through MedImpact's mail order pharmacy or at a CVS retail pharmacy (described below) to be covered by the Plan.

Non-Participating Network Pharmacy

If you do not use a participating network retail pharmacy, you must file a prescription claim for reimbursement with the Fund Office. Claims for prescriptions filled at a non-participating retail pharmacy will be reimbursed at 50% of the in-network pricing less any Cost-Sharing.

Mandatory Choice 90 Program

In addition to the prescription drug Deductible outlined above, you pay a Copayment for each 90-day supply prescription filled under the MedImpact mail program or at CVS retail pharmacies. When you have your 90-day supply prescription filled through mail or at CVS retail pharmacies, you will be charged the applicable Copayment or Coinsurance set forth in the applicable schedule in the "Schedules of Benefits" document.

If you choose a non-preferred brand name drug when a generic drug substitute is available, you are required to pay the applicable Copayment as shown in the applicable schedule in the "Schedules of Benefits" document plus the difference in cost between the non-preferred brand name and the generic equivalent.

Maintenance Medications Reminder: You may fill up to three 34-day supplies of maintenance medications at your local retail pharmacy, after which you must fill your maintenance medication for 90 days either through MedImpact mail or at a CVS retail pharmacy.

You must have the third maintenance medication refill and all subsequent maintenance medication refills filled through the Mandatory Choice 90 Program either through mail or at CVS retail pharmacies.

Prior Authorization (PA)

In order for some prescription medications to be covered as a part of your benefit, a Prior Authorization (PA) evaluation will be conducted to determine if the medication's prescribed use meets defined clinical criteria. Through this process, your Doctor and MedImpact pharmacists will work together to ensure that the drug you are prescribed is the most appropriate for your

condition. The MedImpact Prior Authorization number is 888-807-5745. Please visit www.medimpact.com to determine which drugs require a PA.

You may attempt to fill a prescription for a non-formulary medication which is excluded from coverage. If this happens, there may be a preferred alternative drug recommended by MedImpact. If you and your Doctor do not believe the recommended alternative(s) is appropriate for you, your Doctor can request a Prior Authorization by contacting MedImpact.

If a PA request is subsequently denied, both you and your Doctor will receive written communication from MedImpact, which will outline the process of initiating an appeal. If the appeal is approved, the Plan will then cover the non-formulary medication, subject to the prescription drug Deductible and Copayment or Coinsurance shown in the applicable schedule in the "Schedules of Benefits" document.

If the appeal is denied, you may then choose to file a Second Level appeal as described later in this section. You will receive information on how to file a Second Level appeal through a written communication from MedImpact.

Quantity Limits

Quantity limits are defined as the maximum number of tablets or units (i.e., injections or nasal spray bottles) covered by the Plan per Copayment or Coinsurance amount. These limits are generally set around safety and efficacy established by the drug manufacturer. Please visit www.medimpact.com to determine which drugs have quantity limits.

Specialty Medication Program

The Plan provides a separate specialty medication cost share tier for its pharmacy benefit program. Prior Authorization may apply. Copayments as outlined in the applicable schedule in the "Schedules of Benefits" document. Specialty medication prescriptions will be limited to a 34-day supply. Persons who were receiving specialty medications prior to January 1, 2013 will continue to receive those medications at the retail and mail-order Copayments shown in the applicable schedule in the "Schedules of Benefits" document. Visit www.medimpact.com for more information.

Covered Persons receiving specialty medications included on the Select Drugs and Products List must enroll in the Select Drugs and Products Program. Specialty medications are subject to Prior Authorization, step therapy, and administrative review that mayrequire specific drug distribution channels be used. Failure to obtain Medical Necessity may result in a cost containment penalty equal to 100% reduction in benefits payable.

Utilization Management Program

A Utilization Management Program, including step therapy, Prior Authorization, and quantity limits, applies to certain prescription medications. Under the Utilization Management Program, certain drugs and products may also be completely excluded from coverage under the Plan's

Prescription Drug Benefit. You can contact MedImpact to find out if a prescribed medication or supply is subject to Utilization Management.

Important Coverage Reminder: Products not approved by the U.S. Food and Drug Administration (FDA) as a prescription drug are not covered under the Fund's Prescription Drug Benefit.

Opioid Management Program

The Fund's Opioid Management Program includes several types of safety measures: step therapy, quantity, and day supply limits on prescriptions (first fill and subsequent fills), and prior authorization. For a complete list of edits or if you have specific questions regarding your opioid prescription, please call MedImpact at the phone number listed on the back of your card.

Vaccination Program

Certain vaccines are covered under the Prescription Drug Benefit when they are administered at retail pharmacies. This includes vaccines for influenza (flu), pneumococcal, shingles, RSV, COVID, and TDAP vaccinations. Such vaccines are covered 100% under the Prescription Drug Benefit.

NOTE: The 100% vaccine coverage described in this section is **only** available through the Prescription Drug Benefit and NOT at a CVS MinuteClinic® or similar clinic, or through any other medical provider. See the applicable schedule in the "Schedules of Benefits" document for vaccine coverage provided under the Fund's Comprehensive Major Medical Benefit.

Prescription Drug Appeals

First Level Appeals

When an initial coverage review has been denied, a request for clinical review may be submitted by the Eligible Person, their authorized representative, or their provider within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to the appropriate department for clinical review requests:

- Name of Eligible Person
- Person's Plan ID
- Person's phone number
- The drug name for which benefit coverage has been denied
- A brief description of why the claimant disagrees with the initial adverse benefit determination

- Any additional information that may be relevant to the appeal, including prescriberstatements/letters, bills, or any other documents

Send the information to:

MedImpact
10181 Scripps Gateway Court
San Diego, CA 92131
Fax: 858-790-6022

Standard pre-service appeals are completed no later than 15 days from receipt. Post-service appeals are completed no later than 30 days from submission. Urgent appeals are completed within 72 hours. Covered Persons receiving specialty medications included on the Select Drugs and Products List and enrolled in the Select Drugs and Products Program may, at the discretionof the Plan, have their standard pre-service appeal adjudicated by the Plan or an administrative delegate of the Plan.

Second Level Appeals

When a First Level appeal has been denied, an appeal to the Trustees of the NECA-IBEW Welfare Trust Fund may be submitted by the Eligible Person or their authorized representative within 180 days from the receipt of the notice of the First Level appeal adverse benefit determination. To initiate a Second Level appeal, please submit appeal forms and all relevant information to:

NECA-IBEW Welfare Trust Fund – Attn: Appeals
2120 Hubbard Avenue
Decatur, IL 62526-2871
For Second Level prescription drug appeals, you may obtain appeal forms by:

- Visiting www.neca-ibew.org/resources/documents-and-forms, or
- Contacting the Fund Office at 800-765-4239.

External Appeals

After you have completed the Second Level appeal process, you may have the right to the right to request an external appeal to be reviewed by an independent review organization ("IRO") as required by the Affordable Care Act or No Surprises Act. Generally, external appeals are available for certain claims that involve medical judgment, a recission of coverage, or claims covered by the No Surprises Act. Please refer to the section in this SPD entitled "External Review of Emergency Services, applicable Non-Emergency Services and/or Air Ambulance Services and other eligible claims as required by the No Surprises Act and Affordable Care Act" for more information.

Covered Medications

The following medications are covered when prescribed by a Physician or Dentist and obtained by an Eligible Person, subject to all the provisions outlined in this "Prescription Drug Benefit" section and the applicable schedule in the "Schedules of Benefits" document:

1. Legend medications on the MedImpact formulary
2. Insulin syringes and needles
3. Compound medications containing at least one federal legend ingredient
4. Prescription oral and intrauterine contraceptives
5. Diabetic diagnostics
6. Oral smoking cessation medications
7. Erectile dysfunction medications (e.g., Viagra, Cialis), limited to 10 tablets per month
8. Insulin pumps
9. Continuous glucose monitoring systems

Preventive Medication List

Under the Patient Protection and Affordable Care Act (ACA), certain medications/classes are covered at $0 for certain conditions. Please note that this list may change. For the most up-to-date list or to find out if you qualify for $0 coverage, please visit www.medimpact.com or call MedImpact at the phone number of the back of your pharmacy card.

- Aspirin
- Breast Cancer Prevention
- Bowel Preparation
- Contraceptives
- Fluoride
- Folic Acid
- PrEP for HIV
- Statin
- Vaccines
- Smoking Cessation Medications

Prescription Drug Benefit Exclusions

Benefits are not payable for:

1. Devices of any type, including those approved by the FDA with 510K clearance, even though such devices require a Physician's order, such as, but not limited to, therapeutic devices and artificial appliances; such devices do not include devices that are specifically covered under this section.
2. The medication carbinoxamine.
3. Any charges for the administration or injection of any drug.
4. Any prescription for which an Eligible Person is entitled to receive reimbursement under anyworkers' compensation law or is entitled to receive reimbursement of such prescription Legend Drug without charge from a municipality, state, or federal program, including Title XVIII of the Social Security Act.
5. Any prescription filled in excess of the number specified by the Physician or any refill afterone year from the order of the Physician.
6. Drugs dispensed by a Hospital, Skilled Nursing Facility, or long-term acute care Hospital where the Eligible Person is confined.
7. Any drug labeled "Caution: Limited by Federal Law to Investigational Use" or any Experimental drug.
8. Any drug, the use of which is related to the restoration of fertility or the promotion ofconception.
9. Any drug that has not secured full FDA approval for safety and efficacy.
10. Hair loss products (e.g., topical minoxidil, Rogaine).
11. Drugs used for cosmetic purposes.
12. Over-the-counter medications, including smoking deterrents (such as Nicorette) and vitamins(whether the vitamins are prescribed or not).
13. Anabolic steroids, unless approved through the Prior Authorization process.
14. Any of the circumstances described in the Plan's "General Exclusions and Limitations"section (see page 118).
15. Any drugs or medications that are not Covered Medications.

14. Effective January 1, 2024, the section Prescription Drug Benefit for Participants Eligible for Medicare beginning on page 80 - 86 shall be amended to read as follows:

Prescription Drug Benefit for Retired Participants Eligible for Medicare

If an Eligible Person incurs expenses for prescription drug Covered Medications, benefits will be payable, subject to the provisions explained in this section and in accordance with the limitations set forth in the applicable schedule in the "Schedules of Benefits" document.

The prescription drug plan for retirees and their covered spouses or Dependents who are age 65 or older or otherwise Eligible for Medicare is VibrantRx PDP sponsored by NECA-IBEW. The plan is a prescription drug plan with a Medicare contract offered by MG Insurance Company and affiliated with MedImpact, the Fund's pharmacy benefit manager for Participants and their Dependents who are not Eligible for Medicare. For any questions regarding your Prescription Drug Benefit, please contact VibrantRx Member Services at 1-844-826-3451. TTY users should dial 711.VibrantRx combines a standard Medicare Part D prescription drug plan with additional coverage provided by the Fund to close the gaps between the standard Part D plan and the Plan for Persons who are not Eligible for Medicare.

VibrantRx provides you with the *Evidence of Coverage* that explains your rights and the rulesyou need to follow to get covered services and prescription drugs covered by the Medicare Part D portion of your coverage.

NOTE: Active Employees and their Eligible Dependents are covered under the Prescription Drug Benefit administered by MedImpact, even if they are Eligible for Medicare. See the "Prescription Drug Benefit for Participants Not Eligible for Medicare" section.

Spouses and Dependents of Medicare-Eligible retirees, who themselves are not yet Eligible for Medicare, will be covered under the Prescription Drug Benefit administered by MedImpact (see the previous section) until such time they become Eligible for Medicare.

Prescription Drug Deductible

The prescription drug Deductible for each Calendar Year with respect to each Eligible retiree or Eligible Dependent is in the applicable schedule in the "Schedules of Benefits" document. There is no prescription drug Deductible for the Alternative Plan.

Prescription Drug Benefits Payable

Benefits are payable for prescription drug Covered Expenses dispensed through the Retail Pharmacy Program and the Mail-Order Program, subject to the prescription drug Deductible described above and as shown on the applicable schedule in the "Schedules of Benefits" document.

Formulary

The prescription drug plan uses a four-tier formulary. A formulary is a list of prescribed medications, including generic, brand name (preferred and non-preferred), and high cost or specialty medications, that have proven to be both clinically effective and cost effective.

Medications on the formulary are categorized into four tiers, and these tiers determine your cost for a particular medication. There are preferred products in every therapeutic class in the formulary. Some medications are "excluded" from the formulary, and these medications are not covered under the prescription drug plan. The formulary may change every calendar quarter. Log in to www.MyVibrantRx.com/necaibew and use the drug search tool to find your drug, or call VibrantRx Member Services at 1-844-826-3451. TTY users should dial 711.

Drug Tier	Definition
Tier 1 - Generic	A drug that is equivalent to a brand name prescription. By law, ageneric must contain the same active ingredients as brand name drugs. Therefore, taking a generic drug should treat the condition the same as the brand, but the prescription can be obtained at a lower cost.
Tier 2 - Preferred Brand	Brand name medications that do not have a generic equivalent and are included on a preferred drug list.
Tier 3 - Non-Preferred Brand	Brand name medications that are not on a preferred drug list and are a high cost.
Tier 4 - High-Cost or Specialty	High-cost drugs as defined by Medicare, as well as biotech andother unique drugs; includes both brand and generic drugs.

Retail Pharmacy Program

Once a Covered Person has met the prescription drug Deductible, he or she will pay the applicable Copayment and/or Coinsurance under the Retail Pharmacy Program for each prescription as shown on the applicable schedule in the "Schedules of Benefits" document.

Under Medicare guidelines, a Covered Person can receive either a one-month (34-day) supply of the prescription drug or a long-term supply of up to a 90-day supply under the Retail Pharmacy Program. The amount the Person pays depends on the tier and days' supply of the prescription filled and if a 90-day supply, whether it is filled at a preferred or non-preferred pharmacy. If the actualcost of a drug is less than the normal Copayment or Coinsurance for that drug, the Person will pay the actual cost, not the higher Copayment or Coinsurance.

Non-Participating Pharmacy

Eligible Persons must use a network pharmacy to have their Copayment or Coinsurance count toward their Medicare Part D out-of-pocket costs and Medicare total drug costs, unless it is an emergency or non-routine circumstance. Eligible Persons who fill a prescription at a non-participating pharmacy may have to pay the full cost of the drug at the pharmacy. In this case, a paper claim must be completed and sent to the Fund Office to request reimbursement. The non-participating pharmacy claim will be reimbursed at 50% of the in-network pricing less any Cost-Sharing

Mail-Order Program

Once the Covered Person has met the prescription drug Deductible, he or she will have to pay the applicable Copayment or Coinsurance under the Mail-Order Program through the VibrantRx network mail order pharmacy for each prescription as shown in the applicable schedule in the "Schedules of Benefits" document.

Prior Authorization (PA)

In order for some prescription medications to be covered as a part of your benefit, a Prior Authorization (PA) evaluation will be conducted to determine if the medications' prescribed use meets defined clinical criteria. Through this process, your Doctor and VibrantRx pharmacists will work together to ensure that the drug you are prescribed is the most appropriate for your condition. To contact VibrantRx regarding prior authorization:

Call: Member Services at 1-844-826-3451 TTY users should dial 711
Fax: 1-858-790-7100
Mail: Attn: Prior Authorization Department
VibrantRx
10181 Scripps Gateway Court
San Diego, CA 92131

Please visit www.MyVibrantRx.com/necaibew to check the formulary and determine which drugs have a PA.

You may attempt to fill a prescription for a non-formulary medication which is excluded from coverage. If this happens, there may be a preferred alternative drug recommended by VibrantRx. If you and your Doctor do not believe the recommended alternative(s) is appropriate for you, your Doctor can request a Prior Authorization by contacting VibrantRx.

If a PA request is subsequently denied, both you and your Doctor will receive written communication from VibrantRx which will outline the process of initiating an appeal. If the appeal is approved, the Plan will then cover the non-formulary medication, subject to the prescription drug Deductible and Copayment or Coinsurance shown in the applicable schedule in the "Schedules of Benefits" document.

If the appeal is denied, you may then choose to file additional levels of appeals as described in Chapter 7 of the *Evidenceof Coverage* from VibrantRx. You will receive information on how to file additional levels of appeals through a written communication from VibrantRx.

Quantity Limits

For certain prescription drugs, VibrantRx limits the amount of the prescription drug that you can get each time you fill your prescription. Quantity limits are defined as the maximum numberof tablets or units (i.e., injections or nasal spray bottles) covered by the Plan. For example, if it is normally considered safe to take only one pill per day for a certain drug, VibrantRx may limit coverage for your prescription to no more than one pill per day. These drugs have a "QL" next to them in your formulary or visit www.MyVibrantRx.com/necaibew and check the formulary to determine what drugs have quantity limits.

Specialty Medication Program

The Plan provides a separate specialty medication cost share tier for its pharmacy benefit program. Prior Authorization may apply. Immunosuppressive specialty medications (drugs used for transplants) are included in the specialty medications Copayments as outlined in the applicable schedule in the "Schedules of Benefits" document. Specialty medication prescriptions will be limited to a 34-day supply. Persons who were receiving specialty medications prior to January 1, 2013 will continue to receive those medications at the retail and mail-order Copayments shown in the applicable schedule in the "Schedules of Benefits" document. Visit www.MyVibrantRx.com/necaibew" or call VibrantRx Member Services for more information.

Utilization Management Program

A Utilization Management Program, including Prior Authorization (PA), step therapy (ST), and quantity limits (QL), applies to certain prescription medications. These drugs have a "PA," "ST," or "QL" next to them in your formulary, or visit www.MyVibrantRx.com/necaibew and check the formulary.

Certain drugs and products may also be completely excluded from coverage under the Fund's Prescription Drug Benefit.

Important Coverage Reminder: Products not approved by the U.S. Food and Drug Administration (FDA) as a prescription drug are not covered under the Fund's Prescription Drug Benefit.

Opioid Management Program

The Fund's Opioid Management Program includes several types of safety measures: step therapy, quantity and day supply limits on prescriptions (first fill and subsequent fills), and prior authorization. For a complete list of edits or if you have specific questions regarding your opioid prescription, please call VibrantRx at the phone number listed on the back of your card.

Vaccination Program

Certain vaccines are covered 100% under the prescription drug plan when they are administered at a network Pharmacy. This includes vaccines for influenza (flu) and pneumococcal. See Chapter 4, Section 8 of the *Evidence of Coverage* from VibrantRx for more information about vaccinations. Certain other vaccinations, such as vaccines for shingles and TDAP are only covered by your medical plan. You should contact VibrantRx Member Services before you get a vaccination to find out if your vaccination is covered by the prescription drug plan or your medical plan.

NOTE: You could be assessed all or a portion of your prescription drug Deductible at the pharmacy when obtaining one of these vaccinations. If this happens, please contact the Fund Office to ensure you are reimbursed for such charges.

Prescription Drug Appeals

For drugs covered by the Plan for retired Participants and and/or their Eligible Dependents covered by Medicare, refer to Chapter 7 of the *Evidence of Coverage* from VibrantRx for complete details on the appeal process.

Covered Medications

The drugs included on the VibrantRx formulary are covered by the Plan, but restrictions or limitations may apply.

Through the additional coverage provided by the Fund, you are covered for certain drugs not covered on the VibrantRx formulary. You may also have coverage for certain drugs that Medicare will not cover, such as:

- Prescription drugs when used for the treatment of sexual or erectile dysfunction.
- Certain diabetic supplies not covered by Medicare Part D.

These drugs are also subject to the VibrantRx appeals and exceptions process, and your Copayments or Coinsurance for these drugs will not count toward your Medicare out-of-pocket costs or Medicare total drug costs.

Items excluded from coverage are listed below in this section.

Prescription Drug Benefit Exclusions

Benefits are not payable for:

1. Devices of any type, including those approved by the FDA with 510(k) clearance, even though such devices require a Physician’s order such as, but not limited to, therapeutic devices and artificial appliances; such devices do not include devices that may be coveredunder the VibrantRx PDP or through the additional coverage provided by the Fund.

2. The medication carbinoxamine.
3. Any charges for the administration or injection of any drug.
4. Any prescription for which an Eligible Person is entitled to receive reimbursement under any workers' compensation law or is entitled to receive reimbursement of such prescription Legend Drug without charge from a municipality, state, or federal program, including Title XVIII of the Social Security Act.
5. Any prescription filled in excess of the number specified by the Physician or any refill afterone year from the order of the Physician.
6. Drugs dispensed by a Hospital, Skilled Nursing Facility, or Subacute Rehabilitation Facility where the Eligible Person is confined.
7. Any drug labeled "Caution: Limited by Federal Law to Investigational Use" or any Experimental drug.
8. Any drug, the use of which is related to the restoration of fertility or the promotion of conception.
9. Any drug that has not secured full FDA approval for safety and efficacy.
10. Hair loss products (e.g., topical minoxidil, Rogaine).
11. Drugs used for cosmetic purposes.
12. Over-the-counter medications, including smoking deterrents (such as Nicorette) and vitamins (prescribed vitamins are also not covered).
13. Anabolic steroids, unless approved through the Prior Authorization process.
14. Any of the circumstances described in the "General Plan Exclusions" section.
15. Bulk ingredients when used for compounding (e.g., bulk powders).
16. Any drugs or medications that are not Covered Medications.
17. Additional items excluded from coverage are listed starting on page 118.

15. *Effective January 1, 2024, following the section of the SPD titled "External Review of Emergency Services, applicable Non-Emergency Services and/or Air Ambulance Services as required by the No Suprises Act" shall be amended as follows:*

External Review of Emergency Services, applicable Non-Emergency Services and/or Air Ambulance Services and other eligible claims as required by the No Surprises Act and Affordable Care Act

I. External Review of Standard Claims

This External Review procedure is applicable claims eligible for External Review as required by the No Surprises Act and Affordable Care Act. The Affordable Care Act requires non-grandfathered health plans to have specific rules for external appeals processes. You may request an external appeal review after an initial claim denial and subsequent internal review claim denial if the denied claim involves medical judgment (excluding those that involved only contractual or legal interpretation without any use of legal judgment) or a rescission of coverage. You may also request an external appeal review to dispute determinations that involve

whether the Plan complied with the surprise billing and cost-sharing protections under the No Surprises Act.

Your request for external review of claims subject to the No Surprises Act, must be made, in writing, within four (4) months of the date that you receive notice of an initial adverse benefit determination or adverse Appeal Claim benefit determination. For convenience, these Determinations are referred to below as an "Adverse Determination," unless it is necessary to address them differently.

Because the Plan's internal review and appeals process generally must be exhausted before external review is available, in the normal course, external review of standard claims will only be available for Appeal Claim Benefit Determinations.

You do not need to exhaust the internal review and appeals process if the Plan fails to follow all the requirements for internal review. However, this does not apply to the Plan's minor violations of regulatory procedures or actions that are not prejudicial, are attributable to good cause, or are beyond the control of the Plan and made in the context of a good-faith exchange of information or are not reflective of a pattern or practice of non-compliance.

A. *Preliminary Review*

1. Within five business days of the Plan's receipt of your external review request for a standard claim, the Plan will complete a preliminary review of the request to determine whether:
    a. You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
    b. The Adverse Determination concerns a claim involving a claim eligible for External Review as required by the No Surprises Act or Affordable Care Act.
    c. The Adverse Determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan, or does not relate to a decision made solely on a legal or contractual interpretation of Plan terms;
    c. You have exhausted the Plan's internal claims and appeals process (except in limited, exceptional circumstances); and
    d. You have provided all the information and forms required to process an external review.
2. Within one (1) business day of completing its preliminary review, the Plan will notify you in writing as to whether your application meets the threshold requirements for external review. If applicable, this notification will inform you:
    a. If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).
    b. If your request is not complete, in which case the notice will describe the information or materials needed to make the request complete, and allow you to perfect the

request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

B. ***Review by Independent Review Organization (IRO)***

If the request is complete and eligible, the Plan will assign the request to an IRO. The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The IRO must be accredited by URAC or similar nationally-recognized accrediting organization. The Plan will rotate assignment among at least three (3) IROs with which it contracts.

Once the claim is assigned to an IRO, the following procedure will apply:

1. The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim. Such additional information must be submitted within 10 business days. Information submitted after 10 business days may not be considered by the IRO.
2. Within five business days after the assignment to the IRO, the Plan will provide the IRO with the documents and information it considered in making its Adverse Determination.
3. If you submit additional information related to your claim, the assigned IRO must, within one (1) business day forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if, upon reconsideration, the Plan reverses its Adverse Determination, it will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.
4. The IRO will review all the information and documents timely received. In reaching a decision, the IRO will review the claim de novo (as if it were new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria, and/or the opinion of the IRO's clinical reviewer(s).
5. The assigned IRO will provide written notice of its final external review decision to you and the Plan within 45 days after the IRO receives the request for the external review.
6. The assigned IRO's decision notice will contain:
    a. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the

health care provider, the claim amount [if applicable]), and the reason for the previous denial);

b. The date that the IRO received the assignment to conduct the external review and the date of the IRO decision;

c. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

d. A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

e. A statement that the determination is binding except to the extent that other remedies may be available to you or the Plan under applicable state or federal law;

f. A statement of the opportunity to request the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

g. A statement that judicial review may be available to you; and

h. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

II. Expedited External Review of Claims

You may request an expedited external review if:

1.You receive an adverse Initial Claim Benefit Determination that involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or

2. You receive an adverse Appeal Claim Benefit Determination that involves a medical condition for which the time frame for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or you receive an adverse Appeal Claim Benefit Determination that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

A. Preliminary Review

Immediately upon receipt of the request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review set forth above, in section I.A.1, are met. The Plan will immediately notify you as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information described above in section I.A.2.

B. Review By Independent Review Organization

Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO. The Plan will expeditiously provide or transmit to the

assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review, at the above section I.B. In reaching a decision, the assigned IRO must review the claim *de novo* (as if it were new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above in section I.B.6, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

III. After External Review

If the final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

IV. Payment of Claims

The external review standards provide that an external review decision is binding on the Plan, as well as on the claimant, except to the extent other remedies are available under state or federal law. In addition, such otherwise binding decisions do not preclude the Plan from making payments on the claim or providing benefits to the claimant at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits. The Plan must provide benefits (including making payment on the claim) without delay pursuant to a final external review decision in the claimant's favor, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

V. Elimination of Conflict of Interest

To ensure that the persons involved with adjudicating claims and appeals (such as claims adjudicators and medical experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, or termination) or retention will not be made on the basis of whether that person is likely to support a denial of benefits.

16. *Effective January 1, 2024, the SCHEDULES OF BENEFITS Revised March 2023 shall be amended at pages 2 and 10 by replacing the current text boxes or portions of text boxes with the following text boxes. The amount of the copayments remains the same as is in the current schedules:*

Coinsurance	
• PPO Provider	90% of first $19,000 of Individual Allowable Charges, 100% thereafter
• Non-PPO Provider	70% of first $6,334 of Individual Allowable Charges, 100% thereafter

Calendar Year Coinsurance Out-of-Pocket Maximum, after Deductible	
• Individual	$1,900
• Family Maximum	$3,800

Calendar Year Medical Out-of-Pocket Maximum (includes Deductible, Coinsurance, and Copayments)	
• Individual	$4,725
• Family Maximum	$9,450
A separate maximum applies to Covered Prescription Drug Expenses.	

Calendar Year Prescription Out-of-Pocket Maximum (includes Deductible, Coinsurance, and Copayments)	
• Individual	$4,725
• Family Maximum	$9,450
A separate maximum applies to Covered Medical Expenses.	

17. *Effective January 1, 2024, the SCHEDULES OF BENEFITS Revised March 2023 shall be amended at pages 6 and 14 by replacing the current text boxes or portions of text boxes with the following text boxes. The amount of the copayments remains the same as is in the current schedules:*

Coinsurance	
• PPO Provider	80% of first $15,000 of Individual Allowable Charges, 100% thereafter
• Non-PPO Provider	60% of first $7,500 of Individual Allowable Charges, 100% thereafter

Calendar Year Coinsurance Out-of-Pocket Maximum, after Deductible	
• Individual	$3,000
• Family Maximum	$6,000

Calendar Year Medical Out-of-Pocket Maximum (includes Deductible, Coinsurance, and Copayments) • Individual • Family Maximum **A separate maximum applies to Covered Prescription Drug Expenses.**	 $4,725 $9,450

Calendar Year Prescription Out-of-Pocket Maximum (includes Deductible, Coinsurance, and Copayments) • Individual • Family Maximum **A separate maximum applies to Covered Medical Expenses.**	 $4,725 $9,450

18. *Effective January 1, 2024, the SCHEDULES OF BENEFITS Revised March 2023 shall be amended at pages 4, 11, and 18 by replacing the current text boxes with the following text boxes.*

ORGAN TRANSPLANT BENEFITS THROUGH CENTERS OF EXCELLENCE (COE)	
Transplant surgeries covered are those defined as non-Experimental by the Centers for Medicare & Medicaid Services (CMS) for the condition being treated including, but not limited to, kidney, bone marrow, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney. Pre-certification by the Fund Office is required for Medical Necessity; benefits are not payable if Pre-certification is not obtained. In addition, amounts paid when an out-of-network non-Centers of Excellence (COE) facility is used do not apply to the Out-of-Pocket Maximum. If the Participant or a Dependent is a candidate for transplant surgery, the Participant must contact the Fund Office before incurring any expenses.	
Organ Transplant Calendar Year Deductible Individual Deductible	 Major Medical Deductible of $600
Organ Transplant Coinsurance • COE Facility • PPO Non-COE Facility • Non-PPO Non-COE Facility	 90% of first $19,000 of Allowable Charges, 100% thereafter 50% of Allowable Charges, Medical Out-of-Pocket Maximum applies 50% of Allowable Charges
Organ Transplant Calendar Year Medical Out-of-Pocket Maximum, after Deductible • COE Facility, PPO Non-COE Facility • Out-of-Network Non-COE Facility	 Medical Out-of-Pocket Maximum of $4,725 per individual, $9,450 per family No Medical Out-of-Pocket Maximum

19. *Effective January 1, 2024, the SCHEDULES OF BENEFITS Revised March 2023 shall be amended at pages 8, 15, and 22 by replacing the current text boxes with the following text boxes.*

ORGAN TRANSPLANT BENEFITS THROUGH CENTERS OF EXCELLENCE (COE)

Transplant surgeries covered are those defined as non-Experimental by the Centers for Medicare & Medicaid Services (CMS) for the condition being treated including, but not limited to, kidney, bone marrow, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney. Pre-certification by the Fund Office is required for Medical Necessity; benefits are not payable if Pre-certification is not obtained. In addition, amounts paid when an out-of-network non-Centers of Excellence (COE) facility is used do not apply to the Out-of-Pocket Maximum. If the Participant or a Dependent is a candidate for transplant surgery, the Participant must contact the Fund Office before incurring any expenses.	
Organ Transplant Calendar Year Deductible Individual Deductible	 Major Medical Deductible of $600
Organ Transplant Coinsurance • COE Facility • PPO Non-COE Facility • Non-PPO Non-COE Facility	 80% of first $15,000 of Allowable Charges, 100% thereafter 50% of Allowable Charges, Medical Out-of-Pocket Maximum applies 50% of Allowable Charges
Organ Transplant Calendar Year Medical Out-of-Pocket Maximum, after Deductible • COE Facility, PPO Non-COE Facility • Out-of-Network Non-COE Facility	 Medical Out-of-Pocket Maximum of $4,725 per individual, $9,450 per family No Medical Out-of-Pocket Maximum

20. *Effective January 1, 2024, the SCHEDULES OF BENEFITS Revised March 2023 shall be amended at pages 5, 9, 13, 17, 20, and 24 by adding the following text box before the endnotes of the Prescription Drug Benefit Schedule adding the Prescription Drug Calendar Year Out-of-Pocket Maximum:*

Calendar Year Prescription Drug Out-of-Pocket Maximum (includes Deductible, Coinsurance, and Copayments) • Individual • Family Maximum **A separate maximum applies to Covered Medical Expenses.**	 $4,725 $9,450

21. *Effective January 1, 2024, the following section shall be added after page 133:*

Nondiscrimination in Health Care

Pursuant to Section 2706 of the Public Health Service Act, as amended by the Affordable Care Act, to the extent an item or service is a covered benefit under the Plan, and consistent with reasonable medical management techniques with respect to the frequency, method, treatment or setting for an item or service, the Plan will not discriminate with respect to participation under the Plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. The Plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the Plan or issuer. The Plan is permitted to establish varying reimbursement rates based on quality or performance measures.

Whistleblower Protections

Anti-retaliation protections apply to the Plan, as required under the Affordable Care Act.

IN WITNESS WHEREOF, as authorized by the Board of Trustees, this Amendment No. 8 to the Fund's Summary Plan Description and Plan Document, 2020 Edition, is adopted on the 26th day of October, 2023.

The Board of Trustees, by:

DocuSigned by:
Jarrett Clem
9E0DD8DECA00453...

Chairman – Jarrett Clem

DocuSigned by:
Billy Serbousek
4EA8074485D3497...

Secretary – Billy Serbousek