Amendment 3 to the Ironworkers Intermountain Health and Welfare Plan and Summary Plan Description dated November 1, 2016

WHEREAS, the Third Restated Agreement and Declaration of Trust ("Trust") of the Ironworkers Intermountain Health & Welfare Trust Article V Section 1(b) empowers the Trustees to amend the Ironworkers Intermountain Health and Welfare Plan ("Plan");

AND WHEREAS, the Trustees wish to acknowledge changes made to the Plan by the May 2019 and July 2019 SMMs, and to make certain clarifications to the Plan;

NOW, THEREFORE, BE IT RESOLVED THAT the Plan is amended as follows:

1. **Effective as of August 1, 2019, the portions of the SUMMARY OF BENEFITS entitled *ACCIDENT AND SICKNESS WEEKLY BENEFITS FOR ACTIVE EMPLOYEES, MAXIMUM MEDICAL BENEFITS, MEDICAL BENEFITS: Your calendar Year Deductible/Copays, DENTAL BENEFITS,* and *LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS (ACTIVE EMPLOYEES ONLY)* are amended to read as follows:**

ACCIDENT AND SICKNESS WEEKLY BENEFITS FOR ACTIVE EMPLOYEES

Weekly Benefit	$350 minus FICA tax
Benefit duration per disability	21 weeks
Benefit Commencement: Injury	1st day
Benefit Commencement: Illness	8th day (or 1st day hospitalization)

MAXIMUM MEDICAL BENEFITS

Lifetime Maximums	
TMJ	$2,500
Skilled Nursing Facility	70 days
Other Calendar Year Maximums	
Orthotics	one pair
Chiropractic	20 visits
Acupuncture	20 visits
Anesthesia for oral surgery	$750

MEDICAL BENEFITS: *Your calendar year Deductible/Copays*

	Class I	Class II	Class III	Local 24 & 24A
Individual Deductible	$1,000	$750	$500	PPO - $2,500 non-PPO - $5,000
Maximum Family Deductible	$2,000	$1,500	$1,000	PPO - $5,000 non-PPO - $10,000
Physician/other practitioner office visit Copay	$0	$0	$30	$0
Hospital and other inpatient admission	$100	$100	$100	$0
Emergency Room Copay	$300	$300	$300	$0

* Copays are not applied toward the Deductible or maximum Coinsurance. Deductibles are not applied toward maximum Coinsurance.
* The emergency room Copay is waived if following treatment in the emergency room the Covered Individual is admitted on the same day to a Hospital.
* There is no Copay for acupuncture, chiropractic benefits, or Preventive Care.
* There is no Deductible for Preferred Provider Physician office visits (non-surgical services), chiropractic benefits, and Preventive Care.

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DENTAL BENEFITS

	Adults	Pediatric (under age 19)
Calendar Year Maximum	$2,500	No maximum
Calendar Year Deductible	$25	$25 for basic & major services

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS (ACTIVE EMPLOYEES ONLY)

Active Employee	$20,000

See the attached insurance certificate of coverage for a description of benefits.

2. Effective September 1, 2019, the portions of the SUMMARY OF BENEFITS entitled *MEDICAL BENEFITS: Your calendar year Deductible/Copays* and *MEDICAL BENEFITS: Percentage of Covered Charges you pay – Coinsurance* are amended to read as follows:

MEDICAL BENEFITS: *Your calendar year Deductible/Copays*

	Class I	Class II	Class III	Local 24 & 24A
Individual Deductible	$1,000	$750	$500	PPO - $2,500 non-PPO - $5,000
Maximum Family Deductible	$2,000	$1,500	$1,000	PPO - $5,000 non-PPO - $10,000
Physician/other practitioner office visit	$0	$0	$30	$0
Hospital and other inpatient admission	$100	$100	$100	$0
Emergency Room Copay	$300	$300	$300	$0

* Copays are not applied toward the Deductible or maximum Coinsurance. Deductibles are not applied toward maximum Coinsurance.
* The emergency room Copay is waived if following treatment in the emergency room the Covered Individual is admitted on the same day to a Hospital.
* There is no Copay for acupuncture, chiropractic benefits, Preventive Care, or *Teladoc* program benefits.
* There is no Deductible for Preferred Provider Physician office visits (non-surgical services), chiropractic benefits, Preventive Care, or *Teladoc* program benefits.

MEDICAL BENEFITS: *Percentage of Covered Charges you pay - Coinsurance*

	Class I	Class II	Class III	Local 24 & 24A
PPO (and non-PPO outside PPO Service area) Physician office visits	30%	25%	0%	20%
PPO (and non-PPO outside PPO Service area) services and supplies	30%	25%	20%	20%
Non-PPO services and supplies within PPO Service Area	50%	50%	40%	40%
Preventive Care (PPO only—non-PPO not covered)	0%	0%	0%	0%
Maximum Coinsurance—PPO providers/non-PPO	$4,500/$7,500	$3,750/$7,500	$3,000/$6,000	See Medical Out-of-Pocket Maximum

* If a Covered Individual has surgery performed by a PPO Physician in a PPO facility, other services, such as anesthesia, if rendered by a non-Preferred Provider will be paid at the PPO percentage.
* No Coinsurance is owed for *Teladoc* program benefits.
* In case of a life-threatening Emergency, the Plan pays benefits at the PPO percentage.
* The Plan pays nothing for Preventive Care services and supplies you receive from a non-Preferred Provider. And the Plan pays nothing for non-PPO Licensed Substance Abuse Treatment Centers,

Residential Treatment Facilities, Skilled Nursing Facilities, or Rehabilitation Facilities.

* Only medical benefit Coinsurance counts toward the Coinsurance maximum. For example, outpatient prescription drug payments do not count toward the Coinsurance maximum.

3. Effective January 1, 2020, the portion of the SUMMARY OF BENEFITS entitled *CALENDAR YEAR OUT-OF-POCKET MAXIMUM* is amended to read as follows:

CALENDAR YEAR OUT-OF-POCKET MAXIMUMS

	Self-only coverage		Family coverage	
	Medical and pediatric dental	Out-patient prescription drugs	Medical and pediatric dental	Out-patient prescription drugs
Class I, II & III	$6,120	$1,780	$12,240	$3,560
Local 24 & 24A PPO	$6,310	$1,840	$12,620	$3,680
Local 24 & 24A Non-	$12,620	$3,680	$25,240	$7,360

* The out-of-pocket maximums have the following restrictions:
  - They apply only to Essential Health Benefits, as defined by law and the Plan.
  - They do not apply to cost sharing for vision benefits or adult dental benefits.
  - They apply only to the extent a service or supply is a Covered Charge and, except for members of Locals 24 and 24A, only if received from a PPO including, for prescription drugs, a PPO pharmacy.
  - They do not apply to expenses incurred for services or supplies in excess of another Plan limit, such as a visit limit.
  - They apply only to Covered Charges incurred for the family members you have properly enrolled for coverage in the Plan.
  - If a generic drug is available and you or your doctor choose a brand drug, you pay the difference in cost. That difference will not count toward the out-of-pocket maximums.
  - The maximums renew each calendar year. For example, cost sharing for expenses incurred in 2019 will not apply toward the out-of-pocket maximums in 2020.
  - The out-of-pocket maximums are adjusted annually.
  - Once you reach the out-of-pocket maximum for medical and pediatric dental expenses, you owe no further Deductible, Copay, or Coinsurance for Covered Charges from PPOs that are for medical and pediatric dental expenses for the remainder of the calendar year.
  - Once you reach the out-of-pocket maximum for prescription drugs, you owe no further Copay or Coinsurance for covered drugs received from a PPO pharmacy for the remainder of the calendar year.
  - Even if you reach the out-of-pocket maximums for a year, the Plan's other limits and exclusions continue to apply—for example, the requirement that a service be Medically Necessary and visit limits.

* The maximums listed in the chart above are effective beginning January 1, 2020.

4. Effective August 1, 2019, the PRECERTIFICATION section is amended to read as follows:

PRECERTIFICATION

PRECERTIFY YOUR VISITS TO THE HOSPITAL, AND CERTAIN SERVICES AND SUPPLIES

Precertification is required for all inpatient admissions and certain other services and supplies. If you don't obtain precertification, for some claims the Plan reduces its reimbursements by $200—that means you will have to pay an additional $200 of Covered Charges. For other claims, the Plan pays nothing, as described below.

The following services and supplies require precertification to avoid the $200 penalty: inpatient admissions (and services and supplies received while you are an inpatient), including but not limited to admissions to a Hospital, Skilled Nursing Facility, Rehabilitation Facility, Residential Treatment facility, and Licensed Substance Abuse Treatment Center, Intensive Outpatient Substance Abuse or Mental/Behavioral Health services, Durable Medical Equipment, Home Health Care, home infusion therapy, injectable medications, orthotics and prosthetics, Speech Therapy, therapeutic radiology (brachytherapy, proton beam therapy, neutron beam therapy), sleep studies, spinal procedures, and other surgical procedures rendered in an outpatient facility.

The following services and supplies require precertification to receive any Plan coverage: organ transplants, eye surgeries (LASIK, etc.), hearing aids (see below), compound drugs and specialty drugs.

You can precertify a procedure or hospital admission by calling the Plan's medical reviewer, CIGNA, at (800) 768-4695. The precertification will be provided to you in writing. If the procedure does not require precertification, you will be advised precertification is not needed. If you are uncertain if precertification should be obtained, call CIGNA. Hearing aids are precertified by calling the Hearing Aid Benefit Preferred Provider, and drugs are precertified by calling the Pharmacy Benefit Manager. See the next page (PPOs) for contact information.

In an emergency, you don't have to precertify a hospital admission. But you do have to contact CIGNA within two working days of admission, or the Plan will reduce its reimbursements by $200.

The $200 penalty or nonpayment for failure to precertify does not count toward your Deductible, Coinsurance, or out-of-pocket maximum, unless otherwise required by law.

PRECERTIFY YOUR HEARING AIDS

Precertification is required to obtain a hearing aid. If you don't obtain precertification, the Plan covers no expenses related to a hearing aid.

You can precertify by calling EPIC. Their contact information is in the section below (PPO). The precertification will be provided to you in writing.

You must also purchase your hearing aid through EPIC. See Article VI for details.

5. **Effective August 1, 2019, Plan Section 3.1(b) is amended to read as follows:**

b. Amount of Benefit. $350 per week (less FICA taxes) in which the Participant is disabled every day. The benefit is not paid for days the Participant is not totally disabled, and so is prorated for partial weeks of total disability.

6. **Effective August 1, 2019, Plan Section 7.2(b) is amended to read as follows:**

b. Materials and Dispensing Fee

	Calendar Year Maximum Benefit
Single vision lenses (pair)	$30
Bifocal lenses (pair)	$75
Trifocal lenses (pair)	$90
Lenticular lenses (pair)	$240
Eyeglass lenses for Covered Individuals under age 19	No maximum dollar amount*
Frames	$150
Contact lenses (pair) – following cataract surgery or when visual acuity cannot be corrected to 20/70 in the better eye except by their use	$500
Contact lenses – following a cornea transplant (but only for the affected eye) or in cases of keratoconus	No maximum dollar amount*
Other – when contact lenses are in lieu of glasses (including disposable contact lenses)	$150

* Limited to Medically Necessary lenses

7. **Effective September 1, 2019, the following section is added immediately following the section entitled PREFERRED PROVIDER ORGANIZATIONS (PPOs):**

TELADOC PROGRAM

Teladoc is a telemedicine program that allows you and your enrolled Dependents to consult with a Physician or licensed therapist by phone or videoconference, at no cost. *Teladoc* services are available 24 hours a day, 7 days a week.

Teladoc Physicians can treat many common minor illnesses, such as colds, sore throats, flu, allergies, upset stomach, and pink eye. Where appropriate, Physicians can provide short-term prescriptions and call the prescription in to your preferred local pharmacy. However, Physicians cannot prescribe controlled substances or certain other drugs.

For adults, *Teladoc* also offers confidential counseling with a licensed therapist for behavioral health issues such as depression, anxiety, stress, and marital or family issues. Counseling appointments must be scheduled in advance.

To request services, call *Teladoc* at 1-800-835-2362, visit www.teladoc.com or download the *Teladoc* app. Note that *Teladoc* is not intended for medical emergencies, as a replacement for your primary care Physician, or for management of a chronic or serious condition.

8. Effective September 1, 2019, Plan Sections 4.7(o) & (v) are amended to read as follows:

o. Physician Services. Physician services as follows:

1. daily visits when confined in a Hospital as a registered inpatient,
2. office visits and consultations,
3. emergency room visits, and
4. telemedicine provided through the *Teladoc* program.

Benefits are not payable for charges which are considered post-operative care for which surgical benefits are payable, or any charge for more than one (1) treatment per day, except for a consultation when referred by a Physician.

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v. Mental Health and Substance Abuse Benefits. The Plan provides benefits for Licensed Substance Abuse Treatment Center, Hospital, and Residential Treatment Facility charges for inpatient treatment of a Mental Illness and/or Substance Abuse, Physician Covered Charges incurred for outpatient treatment of a Mental Illness and/or Substance Abuse, and counseling services provided through the *Teladoc* program; however, coverage for Licensed Substance Abuse Treatment Centers and Residential Treatment Facilities is only provided to the extent treatment is received at a PPO facility. Admission should be precertified by the Plan's medical reviewer to avoid a failure to precertify penalty.

9. Effective September 1, 2019, Plan Sections 9.01(z) & (gg) are amended to read as follows:

z. situational disturbances, stress, strain, financial, marital or family counseling, environmental and social maladjustments, dissocial behavior or chronic situation reactions, except as required by law or under the *Teladoc* program.

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gg. reports or appearances in connection with legal proceedings whether or not an Injury or Illness is involved; for Physician's telephone consultations and/or travel time (other than consultations provided through the *Teladoc* program); charges in connection with shipping, handling, postage, interest, or finance.

10. **Effective August 1, 2019, the *Life and Accidental Death and Dismemberment Insurance Certificate* is replaced with the attachment hereto.**

Adopted at a meeting of Trustees on May 5, 2020, with the effective dates as noted herein.

Doug Thomas, Chairman

Lillian Santillanes, Secretary