Iron Workers Health Trust Fund Local No. 5
Washington D.C. Welfare Fund

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Administered by
Welfare & Pension Administration Service, Inc.

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SUMMARY OF MATERIAL MODIFICATION

The Summary Plan Description (SPD), dated January 1, 2020, for the Iron Workers Health Trust Fund Local No. 5, Washington D.C. ("Plan") has been amended by the Board of Trustees.

Effective January 1, 2024, the section entitled "Schedule of Benefits" on page 16 has been amended to reflect coverage of Infertility Services for Participants and Spouses covered by the Plan. As amended, this Section shall read as follows:

The following schedule lists the medical benefits provided under the Plan.

Note, that while it is the intention of the Trustees to maintain and improve the level of benefits as financial conditions permit, none of the benefits or levels of coverage are guaranteed and may be reduced or eliminated if the Trustees determine it is necessary for the financial health of the Plan or for administrative reasons:

The following generally summarizes the out-of-pocket costs that you will pay for services, however there are some exceptions to this that are stated later in this section.

NOTE: Coinsurance that is applied to Infertility Services are not taken into account for determining whether you have reached your Out-of-Pocket maximum.

SUMMARY OF BENEFITS **DEDUCTIBLES & MAXIMUMS**	
Annual Deductible, each covered person	$300
Maximum Family Deductible	$600
Plan Pays	In-Network - 80% Out-of-Network - 70%
You Pay (unless otherwise noted)	In-Network - 20% Out-of-Network - 30% of Allowed Amount plus additional amounts that may be billed directly to you by the provider
Annual Out-of-Pocket Maximum, Medical	$1,500 per Individual; $3,000 per Family
Annual Out-of-Pocket Maximum, Prescription Drug	$1,000 per Individual; $2,000 per Family
Lifetime Maximum for Benefits	Unlimited

Example: If you have an In-Network medical expense totaling $15,000, you are responsible for the first $300 in any calendar year (the Deductible). Once the Deductible is satisfied (and assuming that the expense is a covered item by the Plan and it does not exceed the Allowed Amount), the Plan pays the remaining 80% of the expense, up to the out-of-pocket maximum limitations of the Plan, which would become $1,500 after you meet the Deductible. In this case, of the remaining $14,700, you would be responsible for 20% Coinsurance, or $2,940.

Since this exceeds the out-of-pocket limit, the Plan would reimburse you, or your medical provider for the balance.

PLAN COVERAGE	
Inpatient Hospital Care Hospital Room and Board (subject to pre-certification requirements)	Average semi-private room rate
Emergency Room Care	Subject to Deductible and Coinsurance
Urgent Care center	Paid at 100%, no Deductible.
Inpatient Surgery ♦	Subject to Deductible and Coinsurance, Non-emergency procedures must be pre-certified
Outpatient Surgery ♦	Subject to Deductible and Coinsurance
Maternity Management Program	Covered at 100% with no Copayment or Deductible
Maternity Care (for Participant and Spouse only)	Subject to Deductible and Coinsurance
Infertility Services (for Participant and Spouse only) Artificial Insemination Assisted Reproductive Technologies	Subject to Deductible and Coinsurance Maximum Lifetime benefit of $100,000 Covered In-Network Only at 50% of Allowed Amount, procedures and associated services must be pre-certified Covered In-Network Only at 50% of Allowed Amount, procedures and associated services must be pre-certified
Physician's Office Visits	Subject to Deductible and Coinsurance
Preventive Care	In-Network: Covered at 100% with no Coinsurance or Deductible Out-of-Network: 100% of Allowed Amount, up to $500 calendar-year family maximum. Then subject to Deductible and Coinsurance plus any balance billing.
Mental/Nervous Disorders Inpatient Services Outpatient	 Subject to Deductible and Coinsurance, pre-certification is required, except in the case of emergency inpatient admittance Subject to Deductible and Coinsurance
Substance Abuse Treatment	Subject to Deductible and Coinsurance
Hospice Care Inpatient Services Outpatient	 Limited to $3,000 per period of care Limited to $2,000 per period of care
Chiropractic Care	Subject to Deductible and Coinsurance
Organ Transplants	Subject to Deductible and Coinsurance
Lasik Eye Surgery or Radial Keratotomy	Maximum lifetime allowance of $1,500 per family

- **If two or more surgical operations are performed at the same time, through the same surgical opening, the total amount payable for such operations will be 80% of usual, reasonable and customary for the first procedure and 50% of usual, reasonable and customary for the second.**

Effective January 1, 2024, the following sections have been added to page 31 of the SPD:

Infertility Services Benefit

Effective January 1, 2024, the Plan offers a limited Infertility Services benefit to Participants and Spouses covered under the Plan. Dependent Children covered under the Plan are not eligible for the Infertility Services benefits. Subject to certain exclusions and limitations, benefits for infertility services are limited to:

1. Infertility counseling,
2. Testing,
3. Artificial Insemination; and,
4. Assisted Reproductive Technologies (ART), including:
    a. In-Vitro Fertilization (IVF)
    b. Gamete intrafallopian transfer (GIFT)
    c. Zygote intrafallopian transfer (ZIFT)
    d. Frozen embryo transfer (FET)

Infertility Services Coverage Limitations and Exclusions

1. Assisted reproductive technologies coverage is limited to medically necessary, non-experimental procedures and associated services.
2. Infertility services are not covered where the infertility is related to an elective surgical sterilization procedure with or without reversal.
3. Artificial Insemination procedures and associated services (including intrauterine insemination) must be preauthorized.
4. ART procedures and associated services are limited to all outpatient expenses arising from ART procedures that are performed at medical facilities that conform to standards set by The American College of Obstetricians and Gynecologists; or The American Society of Reproductive Medicine.
5. ART procedures and associated services are covered only when a Participant or Spouse has:
    a. Received qualified physician's diagnosis of infertility; and
    b. Not attained a successful pregnancy through a less costly infertility treatment for which coverage is available; and
    c. Received prior authorization.

Covered Infertility Services charges are subject to the annual Deductible, Copayment amounts, and Coinsurance percentages. Pre-certification is required for Artificial Insemination and ART charges. Other than the amount applied to your annual deductible, if any, the remaining patient liability amounts(non-covered services, coinsurance amounts) will not be applied to your annual out-of-pocket maximum.

Infertility Service charges, including prescription drug costs, are subject to a lifetime maximum benefit of $100,000.

Effective January 1, 2024, the section entitled "Are There Any Drugs That are Not Covered" on page 33 has been amended to reflect limited coverage of infertility services for Participants and Spouses covered by the Plan. As amended, this Section shall read as follows:

Are There Any Drugs That are Not Covered?

Yes. First, not all prescription drugs are covered. Some prescription drugs may be excluded due to cost or unproven efficacy. In most cases when a drug is excluded, the Plan covers one or more alternative drugs that will deliver similar results. Second, the following are not considered Covered Prescription Drugs:

- a non-legend patent or proprietary medicine or medication not requiring a prescription, except insulin, unless two or more such medicines must be compounded according to a written prescription;
- blood or blood plasma;
- a medication which is to be taken by or administered, in whole or in part, to the patient while in a Hospital, rest home, sanitarium, extended care facility, convalescent Hospital, nursing home or similar institution;
- any drug labeled, "Caution - Limited by Federal Law to Investigational Use" or experimental drugs even though a charge is made to the patient;
- therapeutic devices (e.g., syringes, needles, (except when used for insulin injections) braces, etc.);
- charges incurred with respect to a Dependent if he or she is entitled to benefits as an Employee or former Employee;
- charges for canes, crutches, wheelchairs or any means of conveyance or locomotion;
- infertility medication for covered Dependent Children; and
- any drugs for treating erectile dysfunction.

Effective January 1, 2024, the section entitled "General Exclusions and Limitations" on pages 44-49 has been amended to reflect limited coverage of infertility services for Participants and Spouses covered by the Plan. As amended, this Section shall read as follows:

GENERAL EXCLUSIONS AND LIMITATIONS

As a general exclusion, no benefits are payable under the Plan for expenses that exceed the Allowed Amount as determined by the Plan. The term "Allowed Amount" is defined in the definition section of the SPD.

In addition, the Plan covers only those services, procedures and other benefits that are medically necessary and are expressly identified as covered in this SPD; all others are excluded.

As additional guidance on benefits that are not covered, please see the following list of exclusions. Every attempt has been made to provide an exhaustive list of exclusions, however, to the extent a benefit is not included in this SPD as a covered benefit, it is excluded whether or not it is set forth in the following list:

- an autopsy or forensic examination and any related expenses, except as required by the Plan;
- preparation of medical forms, reports, records, bills, claim forms and the like;
- mailing, shipping and handling expenses;
- charges for broken/missed appointments;
- telephone calls, e-mailing charges, charges for calling in a prescription refill, interest charges, late fees, mileage costs and provider administration fees;
- educational services, supplies or equipment, including, but not limited to computers, computer devices/software, printers, books, tutoring or interpreters, visual aids, vision therapy, auditory or speech aids/synthesizers, auxiliary aids such as communication boards, listening systems, devices/ programs/services for behavioral training including intensive intervention programs for behavior change and/or developmental delays or auditory perception or listening/learning skills, programs/ services to remedy or enhance concentration, memory, motivation, reading or self-esteem, etc.,

special education and associated costs in conjunction with sign language education for a patient or family members, and implantable medical identification/tracking devices;

- expenses that exceed any Plan benefit limitation or maximum plan benefit;
- expenses for covered medical services or supplies that are determined by the Plan to exceed the Allowed Amount;
- any bodily injury or illness resulting from or arising out of any employment or occupation for compensation or profit;
- any bodily injury or illness for which benefits are payable under any workers' compensation law, occupational disease law or similar legislation;
- any bodily injury or illness for which care, treatment or supplies are obtained from any federal, state or local government agency or program or from a Hospital or institution owned thereby and for which no bill from the provider is rendered;
- any bodily injury or illness for which medical care, treatment and supplies are available without cost, are not required to be paid or for which there would be no charge if the person receiving the treatment were not covered under this Plan;
- any bodily injury or illness caused by or arising from an act of war, whether declared or not, war-like act, insurrection, rebellion, invasion or a conflict involving armed forces or service in the armed forces;
- services in a U.S. Department of Veterans Affairs Hospital or other military medical facility for treatment of military service-related illnesses or injuries;
- any medical care, treatment or supply not prescribed by or under the direction of a licensed physician;
- services administered by a licensed or unlicensed massage therapist;
- medical services or supplies determined by the Board of Trustees or their agent as not medically necessary for the care or treatment of any bodily injuries or illnesses;
- services to reverse voluntary, surgically-induced infertility;
- expenses for and related to adoption;
- prenatal services, maternity services and prescription drug services related to a pregnancy incurred by a covered person acting as a surrogate mother (gestational carrier) are not covered charges. For the purpose of this plan, the Child of a surrogate mother will not be considered a Dependent of the surrogate mother or her Spouse, if the mother has entered into a contract or other understanding pursuant to which she relinquishes the Child following its birth;
- expenses for pre-implantation genetic diagnosis (PGD) where one or more cells are removed from an embryo and genetically analyzed to determine if it is normal;
- sterilization except for tubal ligation and vasectomy when performed on an out-patient basis;
- surrogate expenses, donor egg/semen or other fees, cryostorage of egg/sperm, ovarian transplant, infertility donor expenses, fetal implants, fetal reduction services, surgical impregnation procedures and reversal of sterilization procedures for covered Participants and spouses
- expenses for the diagnosis and treatment of infertility along with services to induce pregnancy and complications thereof, including, but not limited to services, prescription drugs, procedures or devices to achieve fertility, in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate expenses, donor egg/semen or other fees, cryostorage of egg/sperm, ovarian transplant, infertility donor expenses, fetal implants, fetal reduction services, surgical impregnation procedures and reversal of sterilization procedures for covered Dependent Children;
- any treatment that is not pursuant to generally accepted medical practice;

- cosmetic, plastic or reconstructive surgery as a result of earlier cosmetic, plastic or reconstructive surgery, unless the surgery is necessary due to accidental bodily injury. Cosmetic surgery includes, but is not limited to removal of tattoos, breast augmentation (except reconstructive services after a mastectomy), breast reduction (including treatment of benign gynecomastia in males), elimination of redundant skin of the abdomen, surgery to improve self-esteem or treat psychological symptoms or psychosocial complaints related to one's appearance, treatment of varicose veins, upper eyelid blepharoplasty, cosmetic skin products such as Restylane, Renova or other medical or surgical treatment intended to restore or improve physical appearance, as determined by the Plan;
- the replacement of artificial limbs, eyes or larynx except as expressly permitted as a covered expense;
- Vision therapy (orthoptics) and supplies;
- Orthokeratology lenses for reshaping the cornea of the eye to improve vision;
- any bodily injury or illness resulting from or occurring during the attempt to commit or the commission of a misdemeanor or felony, unless such injury, illness or commission/attempted commission of a misdemeanor or felony is the result of domestic violence or an underlying health factor;
- any bodily injury or illness resulting from participation in a riot;
- charges incurred prior to the individuals becoming covered under this Plan or after termination of eligibility, except as provided under any extension or continuation of benefits provisions of this Plan;
- charges for services and supplies related to weight control and the treatment of obesity, except for charges in connection with gastric bypass surgery performed under the express conditions set forth in the Covered Expenses section of this Plan;
- expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment, and weight training services;
- foods and nutritional/dietary supplements including, but not limited to, home meals, formulas, foods, diets, vitamins, herbs and minerals (whether they can be purchased over-the-counter or require a prescription), except foods and nutritional supplements provided during covered hospitalization, and except for prenatal vitamins or minerals requiring a prescription;
- surgical correction of refractive errors other than those covered by the Lasik eye surgery and radial keratotomy benefit as stated in the Schedule of Benefits;
- supplies or equipment for personal hygiene, comfort or convenience such as telephone, television, or similar items not required for medical care;
- surgical procedures deemed "experimental;"
- maternity benefits other than for eligible Participants and spouses, except that certain prenatal is covered for Dependent Children, as required under the Affordable Care Act;
- treatment for sexual impairment or inadequacy not caused by an organic condition;
- medical, surgical or prescription drug treatment related to transsexual/gender reassignment (sex change) procedures, or the preparation for such procedures, or any complications resulting from such procedures;
- expenses for which a third-party is liable;
- expenses for construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability of a covered individual, including, without limitation, construction or modification of ramps, elevators, hand rails, chair lifts, spas/hot tubs, air conditioning, dehumidification devices, asbestos removal, air filtration/purification, swimming pools, emergency alert system, etc.;
- expenses for and related to travel or transportation (including lodging, meals and related expenses) of a health care provider or a non-covered family member of a covered individual;

- expenses for and related to non-emergency travel or transportation (including lodging, meals and related expenses) of a covered individual for medical treatment;
- use of a private room in a Hospital or other health care facility, unless the facility has only private room accommodations or unless the use of a private room is certified as medically necessary by the patient's physician and approved by the Plan;
- expenses for services provided by any physician or other health care practitioner who is the parent, Spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or Child of the patient or covered employee;
- expenses for the services of a medical student or intern or resident;
- expenses for any physician or other health care practitioner who did not directly provide or supervise medical services to the patient, even if the physician or health care practitioner was available to do so on a stand-by basis;
- expenses for medical services or supplies rendered or provided outside the United States, except for treatment of a medical emergency;
- expenses incurred during travel if a physician or other health care provider has specifically advised against such travel because of the health condition of the covered individual;
- expenses related to online internet consultations with a physician or other health care practitioner, unless such services constitute "Telemedicine Services." Telemedicine Services refers to the use of a combination of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Use of audio-only telephone, electronic mail message (e-mail), or facsimile transmission (FAX) is not considered a Telemedicine Service. Telemedicine Services must meet all the requirements of a face-to-face consultation or contact between a health care provider and a patient for services appropriately provided through Telemedicine Services.
- expenses incurred for injuries caused in a motor vehicle accident if the covered individual was operating the vehicle while intoxicated (i.e., had a blood alcohol level that exceeded the legal limit of the jurisdiction in which the accident occurred or no breathalyzer exam was performed or the person refused to submit to a requested breathalyzer or blood test) or was under the influence of illegal drugs, unless the injuries arise as a result of a physical or mental health condition;
- complications of a non-covered service;
- any surcharge fees resulting from state laws (e.g., New York Health Care Reform Act);
- biofeedback, except for electromyogram (EMG) or thermal biofeedback that is medically necessary as part of an overall treatment plan for the treatment or prevention of migraine headache;
- hypnosis/hypnotherapy;
- Animal -assisted therapy not prescribed by a physician or psychiatrist and any fees over the Allowable Amount; travel and other, similar expenses unrelated to the actual therapy are also excluded;
- services related to reading and learning disorders, dyslexia, educational delays, or vocational disabilities;
- expenses for court-ordered services, parental custody services or adoption services;
- services related to a provider-preventable condition (a provider-preventable condition means a condition that meets the definition of a "health care-acquired condition" or an "other provider-preventable condition" as defined in accordance with Medicare or Medicaid regulations. Conditions include but are not limited to wrong surgical/invasive procedure performed on a patient, surgical/ invasive procedure performed on the wrong body part and surgical/invasive procedure performed on the wrong patient. This exclusion does not apply to a provider who bills for the care of a condition that existed prior to the provider's initiation of treatment for that patient;

- expenses for any items that are not durable medical equipment including, but not limited to, air purifiers, swimming pools, spas, saunas, escalators, lifts, motorized modes of transportation, pillows, mattresses, water beds, and air conditioners;
- expenses for replacement of lost, missing, or stolen, duplicate or personalized corrective appliances, orthotic devices, prosthetic appliances, or durable medical equipment;
- expenses for corrective appliances and durable medical equipment to the extent they exceed the cost of standard models of such appliances or equipment;
- expenses for occupational therapy adaptive supplies and devices used to assist a person in performing activities of daily living including self-help devices such as feeding utensils, reaching tools, devices to assist in dressing and undressing, shower bench, raised toilet seat, etc.;
- expenses for custodial care, regardless of where the services are provided, including, without limitation, adult day care, child day care, services of a homemaker, or personal care, sitter/ companion services;
- expenses for dental services or supplies of any kind, (even if they are necessary because of symptoms, congenital anomaly, illness or injury affecting the mouth or another part of the body) including but not limited to dental prosthetics, endodontics such as root canal, dental restorations, and dental services for the care, filling, removal or replacement of teeth, or the treatment of injuries to or disease of the teeth, gums or structures directly supporting or attached to the teeth, unless related to an accidental injury for which medical treatment is obtained within 6 months of the accident and the dental work is related to the medical work needed to repair the injury;
- expenses for the diagnosis, treatment or prevention of temporomandibular joint (TMJ) dysfunction or syndrome;
- expenses for orthognathic services/surgery for treatment of aesthetic malposition of the bones of the jaw such as with prognathism, retrognathism, temporomandibular joint dysfunction/ syndrome or other cosmetic reasons;
- oral cancer screening services/products such as ViziLite, oral brush biopsy;
- expenses for routine foot care, (including but not limited to trimming of toenails, removal or reduction of corns and callouses, removal of thick/cracked skin on heels, foot massage, hygienic/ preventive care (hygienic/preventive care includes cleaning and soaking of the feet, applying skin creams to help maintain skin tone and other services that are performed when there is no evidence of a localized illness, injury or symptoms involving the foot). Expenses for hand care including manicure and skin conditioning and other hygienic/preventive care performed in the absence of localized illness, injury or symptoms involving the hand;
- expenses for genetic tests, including obtaining a specimen and laboratory analysis, to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics, except when genetic tests are performed in accordance with state-mandated newborn screening and except: (i) pre-parental genetic testing (also called carrier testing) intended to determine if an individual is at risk of passing on a particular genetic mutation, such as a family member who is unaffected but at risk for producing affected Children, and (ii) prenatal genetic testing intended to determine if a developing fetus is a risk for inheriting identifiable genetic diseases or traits except tests using fluid or tissue samples obtained through amniocentesis, chorionic villus sampling (CVS), fetoscopy and alphafetoprotein (AFP) analysis in pregnant women;
- expenses for genetic counseling;
- expenses for and related to hair removal or hair transplants and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription drugs such as Minoxidil, Propecia, Rogaine, Vaniqa; or expenses for and related to hair replacement including, but not limited

to, devices, wigs, toupees and/or hairpieces or hair analysis;

- expenses for and related to repairs to hearing aids including replacement parts, lost, stolen or missing hearing aids, hearing aid batteries and other hearing aid accessories including dri aid kits and phone pads;
- expenses for any home health care services other than part-time, intermittent skilled nursing services and supplies;
- expenses under a home health care program for services that are provided by someone who ordinarily lives in the patient's home or is a parent, spouse, sibling by birth or marriage, or Child of the patient; or when the patient is not under the continuing care of a physician;
- expenses for childbirth education, Lamaze classes, breast-feeding classes;
- expenses related to the maternity care and delivery expenses associated with a surrogate mother's pregnancy;
- expenses related to cryostorage of umbilical cord blood or other tissue or organs;
- expenses for virtual colonoscopy (also called 3-dimensional computed tomographic (CT) colonography, CT colonography), except if this procedure is payable if medically necessary for evaluation of the colon in a person with a known colon obstruction, colon lesion or technical difficulty that prevents use of a traditional endoscopic colonoscopy;
- expenses for services of private duty nurses/health care personnel;
- expenses for prophylactic surgery when surgery is prescribed or performed for the purpose of: (i) avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on family history and/or genetic test results; or (ii) treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder;
- expenses for educational, job training, vocational rehabilitation, respite care or recreational therapy;
- expenses incurred at an inpatient rehabilitation facility for any inpatient rehabilitation therapy services provided to an individual who is unconscious, comatose, or in the judgment of the Plan, is otherwise incapable of conscious participation in the therapy services and/or unable to learn and/ or remember what is taught, including, but not limited to coma stimulation programs and like services;
- expenses for prolotherapy (injection of sclerosing solutions into joints, muscles, or ligaments);
- expenses related to the medical or surgical treatment of sleep disorders or snoring including medical equipment, except that coverage is provided for diagnostic sleep studies and for treatment of documented obstructive sleep apnea;
- expenses for tobacco/smoking cessation products such as nicotine gum or patches, or other services or programs;
- expenses for human organ and/or tissue transplants that are experimental including, but not limited to, donor screening, acquisition and selection, organ or tissue removal, transportation, transplants, postoperative services and drugs/medicines and all complications thereof;
- expenses related to non-human (Xenografted) organ and/or tissue transplants or implants, except heart valves;
- transplant donor expenses unless the person who receives the donated organ/tissue is a person covered by this Plan;

Board of Trustees
Iron Workers Health Trust Fund Local No. 5, Washington D.C.