SEVENTH AMENDMENT TO THE INDIANA/KENTUCKY/OHIO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND PLAN DOCUMENT EFFECTIVE JANUARY 1, 2022

WHEREAS, the Trustees of the Indiana/Kentucky/Ohio Regional Council of Carpenters Welfare Fund desire to amend the Plan document effective January 1, 2022 (the Plan);

WHEREAS, the Plan and the Indiana/Kentucky/Ohio Regional Council of Carpenters Welfare Fund Trust authorize the Trustees to amend the Plan from time to time;

NOW, THEREFORE, the Plan is amended as follows effective January 1, 2024, unless otherwise indicated:

1. Article 3, Section 3.2(a) is amended as follows:

	Active Employees and Non-Medicare Retirees	
Medical Benefits	**In-Network**	**Out-of-Network**
~~LiveHealth – On Line~~Telehealth: Teladoc – see Section 3.2(e) below	100%	No coverage

2. Article 3, Section 3.2(b), Exclusions and Limitations, is amended as follows:

(18) For weight reduction programs or treatment for obesity, except as provided under Section 3.2(a) and certain weight loss drugs covered under Section 3.3(b)(5) and 4.2, or any surgery for the removal of excess fat or skin following weight loss, services at a health spa, similar facility, or psychiatric services for weight loss, regardless of Medical Necessity.

* * *

(55) All FDA-approved Cellular and Gene Therapy products.

(~~55~~56) Received outside of the United States of America for a non-Emergency Medical Condition (charges will only be covered for medical services necessary to treat an Emergency Medical Condition in a foreign country and will not include charges for travel or repatriation).

3. Article 3, Section 3.2(e), MDLive, is amended as follows:

(e) ~~MDLive~~Teladoc.

~~MDLive~~ Teladoc is a program that allows Covered Persons to contact a Physician online (with a webcam) or though a smartphone 24 hours a day, 7 days a week, for non-emergency issues. ~~MDLive~~ Teladoc is accessible at ~~mdlive.com/ibxtpa~~www.TeladocHealth.com or via telephone at 1-800-835-2362.

Telehealth: Visits through ~~LiveHealth Online~~Teladoc are covered 100% (in-network only).

4. Article 3, Section 3.3, Prescription Drugs, Paragraph (b), Covered Drugs, is amended as follows, effective December 1, 2023:

(b) Covered Drugs

(1) All Federal Legend drugs; including oral contraceptives and other birth control devices;

(2) Self-administered injectables and certain specialty drugs;

(3) Syringes for self-administered injectables;

(4) Pre-natal vitamins prescribed during pregnancy; and

(5) Notwithstanding any other term of this Plan to the contrary, the Plan will cover certain weight loss drugs, subject to the specific eligibility criteria applicable to each drug, which generally will require the individual:

(a) Be at least 18 years of age;
(b) Engage in behavioral modification and a reduced-calorie diet (which may be required prior to the commencement of drug coverage); and
(c) Have a Body Mass Index (BMI):
(i) Equal or greater than 30; or
(ii) Equal or greater than 27 and at least one of the following risk factors:
(A) Type 2 diabetes;
(B) Hypertension;
(C) Dyslipidemia;
(D) Obstructive sleep apnea; or
(E) Cardiovascular disease.

A list of covered weight loss drugs, and the applicable drug eligibility criteria, both of which may change from time to time, is available at the Fund Office or by contacting ExpressScripts, the Pharmacy Benefits Manager (PBM) at 855-837-3582.

5. The introductory paragraph to Article 14, Internal Claims and Appeals Process, is amended as follows:

ARTICLE 14 – INTERNAL CLAIMS AND APPEALS PROCESS

All benefits provided by this Plan are governed by the terms of these Articles 14 and 15, where applicable, except as follows:

- **For benefits provided under the fully insured policies, including life insurance, claims and appeals will be governed solely by the procedures set forth in the documents governing such benefits~~, and not by the provisions of this Article 14 and 15~~.**

- **Medical benefits administered by Independence Blue Cross (Independence) are governed by the provisions of Article 14A.**

6. Article 14A is added, stating the following:

ARTICLE 14A – CLAIMS AND APPEALS PROCESS FOR MEDICAL BENEFITS ADMINISTERED BY INDEPENDENCE BLUE CROSS

14A.1 Definitions

For purposes of the procedures set forth below, the following terms are used to define health claims and appeals:

(a) **Grievances.** Grievances are appeals arising from the denial of claims for lack of Medical Necessity. In other words, if a claim is denied because it does not meet the standard of Medically Necessary (or Medical Necessity), a Grievance may be filed, subject to the requirements of this section. The Medically Necessary standard is defined in Article 1. Grievances are also referred to as Medical Necessity Appeals

(b) **Complaints.** Complaints are appeals arising from the denial of claims for any reason other than a lack of Medical Necessity. These include, but are not limited to, a denial due to lack of eligibility, the application of plan exclusions, etc. Complaints are also referred to as Administrative Appeals.

(c) **Pre-Service Health Claims.** A request for benefits that, under the terms of the Plan, must be pre-certified or pre-approved (sometimes referred to a requiring prior authorization) before the medical care is obtained for coverage to be available.

(d) **Post-Service Health Claims.** Any request for benefits that is not a Pre-Service Health Claims.

(e) **Urgent or Expedited Appeals.** Any Appeal for medical care or treatment with respect to which the application of the time periods for making non-urgent determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or in the opinion of a physician with knowledge of the Claimant's medical condition would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Appeal. Post-Service Health Claims concerning medical care or treatment that the Claimant has already obtained do not qualify for an Urgent or Expediated Appeal.

14A.2 Initial Submission of Claims

Most claims will be submitted directly from the provider to the appropriate party. However, if they are not, claims for benefits covered under this Article 14A must be submitted to Independence within 365 days of the date incurred.

14A.3 Levels of Appeals for Grievances and Complaints

For both Grievances and Complaints, there are two levels of appeals: First Level Appeals and Second Level Appeals. In other words, upon receipt of a claim denial, a First Level Appeal may be filed. If the First Level Appeal is denied, then a Second Level Appeal may be filed.

The procedures for First and Second Level Appeals are as follows:

		Grievances (Medical Necessity Appeals)	**Complaints (Administrative Appeals)**
First Level Appeals	***Deadline to file?***	180 days from the date of receipt of the original claim denial.	180 days from the date of receipt of the original claim denial.
	Where to file?	Independence Administrators Appeals Department P.O. Box 21545 Eagan, MN 55121 Phone: 1-800-952-3404 / Fax: (215) 761-0956	Independence Administrators Appeals Department P.O. Box 21545 Eagan, MN 55121 Phone: 1-800-952-3404 / Fax: (215) 761-0956
	Who Makes the Decision?	For Grievances, the First Level Appeal is decided by an Independence Peer Consultant in the same or similar specialty as the attending Physician.	For Complaints, the First Level Appeal is decided by Administrative Appeal Committee.
	Decision Timeline?	**Pre-Service Heath Claims:** 30 calendar days from the receipt of the appeal request. **Post-Service Health Claims:** 60 calendar days from the receipt of the appeal request **Urgent or Expedited Appeals:** 72 hours from the receipt of the appeal request. Applicable to Pre-Service Health Claims, only.	**Pre-Service Heath Claims:** 15 calendar days from the receipt of the appeal request. **Post-Service Health Claims:** 30 calendar days from the receipt of the appeal request. **Urgent or Expedited Appeals:** 72 hours from the receipt of the appeal request. Applicable to Pre-Service Health Claims, only.
Second Level Appeals	***Deadline to file?***	**Standard External Review:** 180 days from the date of the First Level Appeal denial. **Expedited External Review:** 72 hours from receipt of the First Level Appeal decision.	60 days from the date of the First Level Appeal denial.
	Where to file?	Independence Administrators Appeals Department P.O. Box 21974 Eagan, MN 55121	The Board of Trustees of the Ohio Carpenters' Health Fund c/o BeneSys Inc. 700 Tower Drive., Suite 300

	Grievances (Medical Necessity Appeals)	Complaints (Administrative Appeals)
	Phone: 1-8880234-2393 / Fax: (215) 761-0956	Troy, MI 48098
Who makes the decision?	For Grievances, the Second Level Appeal is decided by an Independent Review Organization (IRO) (another terms may be External Review Organization (ERO)). The IRO has no direct or indirect professional, familial, or financial conflicts of interest with the entity involved with the original benefit determination or the First Level Appeal decision.	For Complaints, the Second Level Appeal is decided by the Fund's Board of Trustees.
Decision Timeline?	**Standard External Review:** 45 calendar days from the receipt of the request for External Review. **Expediated External Review:** 72 hours from the receipt of the request for External Review.	**Pre-Service Heath Claims:** 30 calendar days from receipt of the Second Level Appeal requests. **Post-Service Health Claims:** The Trustees will decide the Second Level Appeal at the next regularly scheduled Board Meeting, unless the appeal is filed within 30 days preceding the date of such meeting. In such case, the Trustees will decide the appeal no later than the date of the second regularly scheduled Board Meeting following the receipt of the Second Level Appeal request. **Urgent or Expedited Appeals:** 72 hours from receipt of the Second Level Appeal request.

14A.4 Timely Submission of Appeals

All appeals must be timely submitted in accordance with the deadlines detailed in Section 14A.3. Failure to timely submit an appeal results in a waiver of any right to have the benefit claim subsequently reviewed on First or Second Level Appeals, External Review, or in a Court of Law.

14A. 5 Discretion of Trustees

The Trustees or Independence, as applicable, in making Second Level Appeal decisions, have full discretionary authority to determine eligibility for benefits, interpret plan documents, and determine the amount of benefits due. Their decision, if not in conflict with any applicable law or governmental regulation, is finding and conclusive on all interested parties.

14A.6 Incorporation of Certain Provisions from Article 14.

The following provisions apply and are explicitly incorporated into this Article 14A (in such incorporated provisions, any reference to the "Fund" or the "Plan" will be also mean any entity involved in the original benefit determination or First and Second Level Appeals determinations, as relevant):

(a) Section 14.6 (Adverse Benefit Determination);
(b) Section 14.7(d) (Internal Appeals; Notice of Decision on Appeal);
(c) Section 14.8 (Deemed Exhaustion of Internal Claims and Appeals Processes); and
(d) Section 14.10 (Limitations of Actions).

7. Article 25, Service Providers, is deleted and replaced with the following:

Third Party Administrator/ Fund Office BeneSys, Inc. 700 Tower Drive, Suite 300 Troy, MI 48098 (248) 813-9800	**Legal Counsel** AsherKelly 25800 Northwestern Highway, Suite 1100 Southfield, MI 48075 (248) 746-2710
Benefit Consultant/Actuary United Actuarial Services, Inc. 11590 N. Meridian Street, Suite 610 Carmel, IN 46032	**Medical Claims Administrator / Precertification** Independence Administrators (833) 242-3330
Medical PPO Network Independence Blue Cross (833) 242-3330	**Prescription Network** Express Scripts PO Box 747000 Cincinnati, OH 45274-7000 (800) 867-4518 www.express-scripts.com
Dental PPO Network Delta Dental PO Box 9085 Farmington Hills, MI 48333-9085 (800) 524-0149 www.deltadentalin.com	**Vision Network** Vision Service Plan (VSP) (800) 877-7195 www.vsp.com
Medicare Advantage Plan Humana (800) 733-9064 www.humana.com	**Specialty Pharmacy Savings Plan** Saveon SO (800) 683-1074
Diabetic Testing Supplies OneHealth (877) 316-2460 www.D360.care	**Life Insurance** Anthem Life Insurance Company Participants directed to BeneSys for Information 800-447-0460
Telehealth Teladoc www.TeladocHealth.com 1-800-835-2362	

8. **Article 25, Children's Health Insurance Program Reauthorization Act, is renumbered as Article 26.**

By our signatures below, we certify that the above amendment was adopted by the Board of Trustees on 12/20**, 2023.**

Indiana/Kentucky/Ohio Regional Council of Carpenters Welfare Fund

Matt McGriff, Co-Chairman

Date: 12/20/23

William Nix, Co-Chairman

Date: 12/20/23

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