THIRD 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;

WHEREAS, the Plan and Trust authorize the Trustees to amend the Plan from time to time;

NOW THEREFORE, the Plan is amended as follows:

1. Article 3.3(d), Prescription Drug, Copayment and Maximum Out of Pocket Costs for Actives and Non-Medicare Retirees and Dependents is amended as follows to reflect the current co-payment structure:

(d) Co-payments and Maximum Out of Pocket Costs

Most prescription drugs will be subject to the copayments set forth in the table below, Specialty Drugs are covered through the Saveon SP Program and are subject to the cost sharing requirements as set forth by Saveon SP. Specialty drugs are limited to a 30-day supply per fill.

The following copayments apply:

Retail (up to 30 day supply)* (first three refills of same drug)	
Tier 1	Generic: $20~~10~~
Tier 2	Formulary Brand: $40~~38~~
Tier 3	Non-formulary Brand: $80~~63~~
Tier 4	Specialty: 25% up to $200
Retail (up to 30 day supply)* (fourth or more refills of same drug)	
Tier 1	Generic: 100% up to $100
Tier 2	Formulary Brand: 100% up to $100
Tier 3	Non-formulary Brand: 100% up to $100
Mail Order (up to 90 day supply)*	
Tier 1	Generic: $~~17.50~~50
~~Tier 2~~	Formulary: $~~95.00~~100
Tier 3	Non-Formulary Brand: $~~159.00~~200
Tier 4	Specialty: ~~N/A~~25% up to $200

*This chart sets forth amounts paid by the Covered Person at participating pharmacies. As noted above, Covered Persons that utilize a non-

participating pharmacy must pay the entire cost of the drug at the time of purchase and submit original receipts for reimbursement, not to exceed the amount the Fund would have paid a participating pharmacy, to the Fund Office.

Maintenance Drugs: Maintenance drugs, which are drugs taken longer than 90 days, may use Mail Order Pharmacies. There is no limitation on the number of times a prescription may be refilled by mail order. The Plan pays 100% of the cost of the drug **after** payment of the applicable co-payment.

Maximum Out-of-Pocket Costs: There is an annual in-network maximum out-of-pocket costs for prescription drugs purchased with participating pharmacies, which will be adjusted annually. This maximum is the difference between the maximum in-network out-of-pocket for medical and prescription drugs established by Health Care Reform, as adjusted annually, and the maximum out-of-pocket for in-network medical set forth in the chart in section 3.2(b). For example, for 2022, the maximum in-network out of pocket costs for medical and prescription drugs established by Health Care Reform is $8,700 ($9,100 for 2023) for single coverage and $17,400 ($18,200 for 2023) for family coverage. The maximum out-of-pocket for medical expenses under this Plan, as set forth in the chart at section 3.2(b), is $5,000 for single in-network coverage and $10,000 for in-network family coverage. Thus, the 2022 maximum out-of- pocket costs for in-network prescription drugs is $3,700 ($4,100 for 2023) single and $7,400 ($8,200 for 2023) family. There is no out-of-pocket maximum for drugs obtained from non-participating (i.e. out of network) pharmacies.

Diabetic Test Supplies: These are provided without cost sharing for the Covered Person. A list of covered diabetic test supplies is available at the Plan Office, and include blood glucose monitors, test strips, lancets, alcohol prep pads, blood ketone test strips, and insulin pumps.

2. Article 4, Benefits for Medicare Eligible Participants is amended as follows:

4.1 Medical Benefits

(a) General

The coverages set forth in this Article 4 applies to all Medicare-eligible Participants and Dependents, whether eligibility for Medicare is based on age, disability, or end stage renal disease (Non-Medicare eligible dependents of Medicare eligible Participants are covered under the Fund's self-insured medical and drug plan set forth in Article 3.)

This Plan provides benefits as if Medicare eligible Participant or Dependent obtained Medicare coverage when first eligible to do so, even if this is not the

case. It is the Participant's or Dependent's responsibility to timely obtain Medicare coverage. If he/she does not do so, he/she is responsible for the costs of medical expenses that otherwise would have been covered by Medicare, the Medicare Policy (section 4.1(a)), or otherwise under the terms of this Plan as if Medicare had been timely obtained. This Plan will not pay benefits that would have been paid by Medicare. It is recommended that a Retiree, Spouse, or an Employee contemplating retirement, contact the Social Security Administration at least 4 months before they will reach age 65.

All Medicare eligible Participants and Dependents must have Medicare Parts A and B in order to receive benefits under Article 4. ~~In addition, the Prescription Drug Card Benefit is not available to Covered Person enrolled in Medicare Part D.~~

(b) Medical Benefits

Medicare eligible Participants and Dependents are provided medical coverage via a fully insured Medicare coordinated policy (Medicare Policy) through Humana. The terms and conditions of such coverage are set forth in the Medicare Policy. This Fund does not cover any medical expenses for Medicare eligible Participants or Dependents. All such expenses are covered by Medicare or the Medicare Policy. See Article 24 for contact information.

4.2 Prescription Drug Coverage for Medicare Eligible Participants and Dependents Benefit

Medicare eligible Participants and Dependents who are covered by the Medicare Policy under Section 4.1(b), also have prescription drug benefits under an Employer Group Waiver Plan (EGWP). No coverage is provided if the Covered Person is enrolled in Medicare Part D. ~~For more information regarding the Prescription Drug Card Benefit, refer to Section 3.3.~~

The following is a summary of the EGWP. Benefits, formulary, pharmacy network, premiums and/or co-payments/coinsurance may change on January 1 of each year.

(a) Employer Group Waiver Plan

The Plan has contracted with a Pharmacy Benefit Manager, Express Scripts to administer a prescription drug program known as an Employer Group Waiver Plan (EGWP).

The amount of coverage depends upon the annual out of pocket costs incurred by a Covered Person, as follows:

Deductible Stage: $200 deductible must be paid by each Covered Person before coverage provided by Plan.

Initial Coverage Stage: After deductible satisfied, Covered Person pays the following copayments until a Covered Person's total annual drug cost (what the Covered Person and Plan pay, combined) equals the CMS Standard to enter the Coverage Gap (in 2022, this is $4,430; in 2023, this is $4,660):

Retail (up to 31-day supply)	
Tier 1	Generic: $10
Tier 2	Preferred Brand: $38
Tier 3	Non-Preferred Brand: $63
Retail (32-to-60-day supply)*	
Tier 1	Generic: $20
Tier 2	Preferred Brand: $76
Tier 3	Non-Preferred Brand: $126
Retail (up to 90-day supply) **	
Tier 1	Generic: $30
Tier 2	Preferred Brand: $114
Tier 3	Non-Preferred Brand: $189
Smart 90 Pharmacies	
Tier 1	Generic: $17.50
Tier 2	Preferred Brand: $95.00
Tier 3	Non-Preferred Brand: $159
Tier 4	Specialty: N/A
Mail Order (up to 90-day supply)	
Tier 1	Generic: $17.50
Tier 2	Preferred Brand: $95.00
Tier 3	Non-Preferred Brand: $159

*Does not apply to Smart 90 pharmacies.

**Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply.

Coverage Gap Stage: After annual total costs (Covered Person and Plan) equal the CMS Standard to enter the Coverage Gap (in 2022, this is $4,430; in 2023, this is $4,660), a Covered Person will pay the following copayments until his/her own out-of-pocket drug costs reach the CMS TrOOP Limit to enter Catastrophic Coverage (in 2022 this is $7,050; in 2023 this is $7,400):

Retail (up to 31-day supply)	
Tier 1	Generic: $10
Tier 2	Preferred Brand: $38
Tier 3	Non-Preferred Brand: $63
Retail (32-to-60-day supply)	
Tier 1	Generic: $20
Tier 2	Preferred Brand: $76
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*Does not apply to Smart 90 pharmacies.
**Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply.

Catastrophic Coverage Stage: After a Covered Person's yearly out-of-pocket drug costs reach the CMS TrOOP Limit to enter Catastrophic Coverage (in 2022 this is $7,050; in 2023 this is $7,400), a Covered Person will pay the greater of 5% coinsurance or:

- a $3.95 for 2022 ($4.15 for 2023, subject to further annual adjustment) copayment for covered generic drugs, not to exceed the copayment that would be charged if the Covered Person was in the Initial Coverage stage, or
- a $9.85 for 2022 ($10.35 for 2023, subject to further annual adjustment) copayment for all other covered drugs, not to exceed the copayment that would be charged if the Covered Person was in the Initial Coverage stage.

Provisions applicable to all Coverage Stages:

- The Plan may require Covered Persons to try one drug to treat a condition before it will cover another drug for that same condition (e.g., step therapy), or require prior authorization prior to filling a prescription. Contact the PBM for this information.
- If the actual cost of a drug is less than the co-payment for that drug, the Covered Person will pay the actual cost.

3. The Plan is amended by the addition of the following article effective January 1, 2022:

ARTICLE 25 – CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT

Under the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIP"), Participants and Dependents who are eligible for coverage but who are not enrolled for

coverage may exercise special enrollment rights and enroll in the Plan if the Covered Person:

(a) loses coverage under a Medicaid Plan under Title XIX of the Social Security Act; or
(b) loses coverage under State Children's Health Insurance Program ("SCHIP") under Title XXI of the Social Security Act; or
(c) becomes eligible for group health plan premium assistance under Medicaid or SCHIP.

If any of these circumstances arises and the Covered Person wishes to take advantage of these special enrollment rights, the Covered Person must request to enroll for coverage within 60 days from the date:

(a) the coverage terminates under the Medicaid Plan or SCHIP; or
(b) the Participant or Dependent child is determined eligible for state premium assistance.

If you believe you are eligible for special enrollment under CHIP, you must contact the Fund Office to request an election form as soon as possible. A request for enrollment must be made in writing on the form provided by the Fund Office. Requests for special enrollment must be made within 60 days after an event described above.

By our signatures below, we certify that the above amendment was adopted by the Board of Trustees on _____, 2022.

INDIANA/KENTUCKY/OHIO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND

_____ Co-Chair

_____ Co- Chair

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