AMENDMENT 8

TO THE

IRON WORKERS ST. LOUIS DISTRICT COUNCIL WELFARE PLAN

The SPD/Plan is amended to read as follows:

1. Article I is amended by adding the following service provider.

   - Hearing Aids – the Fund provides coverage for hearing aids to participants who have eligibility. In-network coverage is provided through Ear Professional International Corporation (EPIC).

2. Article II, Contact Information is amended to read as follows:

If you or your providers have questions or need information about:	Contact:	At:
Eligibility, Benefits and Claims	Fund Office through BeneSys, Inc.	1-877-597-8704 www.iwstldc.org
Medical Network Providers	Anthem	1-800-810-2583 www.anthem.com
Medical Management Review	HealthLink	1-877-284-0102
Pharmacy Benefit Manager	LDI Pharmacy Benefit Services	1-866-516-3121 www.ldirx.com
Dental Network Provider	Delta Dental of Missouri	1-800-335-8266 www.deltadentalmo.com/ironworkers
Vision Network Provider	VSP Vision Care (VSP)	1-800-877-7195 www.vsp.com
Life Insurance	The Union Labor Life Insurance Company	1-866-795-0680 www.ullico.com
Hearing Aid Provider	Ear Professional International Corporation (EPIC)	1-866-956-5400 www.epichearing.com

3. Article III, Summary of Medical Benefits is revised to change the visit limitation on speech therapy for children under 6 years and to change the benefit for hearing aids. The limit of 60 combined visits for physical, occupational and speech therapy will also apply to children under 6.

ARTICLE III
SUMMARY OF MEDICAL BENEFITS

Section 3.01 Schedule of Medical Benefits—All Locals Except 321 and 577

The following chart highlights key features of the PPO plan provided to eligible Active and non-Medicare-eligible retired Participants and their Dependents participating in all Locals, except Local 321. A chart setting out the benefits for Participants and Dependents whose home Local is 321 follows.

Comprehensive Medical Expense Benefit All Locals Except Locals 321 and 577		
Benefit	**In-Network**	**Out-of-Network** [1]
Deductible Individual Family	 $400 $1,200	 $700 $1,400
Coinsurance	You pay 10%; Plan pays 90% after deductible	You pay 30%; Plan pays 70% after deductible
Annual Out-of-Pocket Maximum [2] Individual Family	 $700 $2,100	 $1,400 $2,800
Doctor Office Visits/Specialist Office Visits -- Covered services include the office visit, and related diagnostic tests and procedures (e.g., x-ray, lab, office surgery) whether rendered in a doctor's office, clinic or other facility not part of a hospital outpatient or inpatient department	You pay a $25 co-payment; Plan pays 100% after co-payment	You pay 30%; Plan pays 70% after deductible
Hospital Inpatient and Outpatient Services, including outpatient surgery, hospital urgent care facility, hospital testing center, and organ and tissue transplants	You pay 10%; Plan pays 90% after deductible	You pay 30%; Plan pays 70% after deductible
Home Health Care and Hospice	You pay 10%; Plan pays 90% after deductible	You pay 30%; Plan pays 70% after deductible

[1] If no in-network provider is located within 25 miles of a Participant's or Dependent's primary residence or if the Participant or Dependent needs the care when he or she is more than 150 miles away from home and more than 25 miles from any in-network provider providing the type of care sought, then in-network benefit levels apply for out-of-network providers.

[2] Co-payments (including prescription drug co-payments), and deductibles do not count toward the out-of-pocket maximum. However, co-insurance does count towards the out-of-pocket maximum.

Benefit	In-Network	Out-of-Network[1]
Maternity Care, Office Visits -- Covered services include the office visit, and related diagnostic tests and procedures (e.g., x-ray, lab, office surgery) whether rendered in a doctor's office, clinic or other facility not part of a hospital outpatient or inpatient department	You pay a $25 co-payment for first visit only if billed separately from the delivery fee for confirmation of the pregnancy	You pay 30%; Plan pays 70% after deductible
Skilled Nursing Facility (in lieu of inpatient hospital admission when approved by Plan. Semi-private room)	You pay 10%; Plan pays 90% after deductible	You pay 30%; Plan pays 70% after deductible
Admission Limitation	45 days per benefit period	
Preventive Care Services – Includes standard immunizations and those services recommended by the U.S. Preventive Services Task Force at the time the service is provided including, as appropriate for the age and gender of the individual, mammograms, colonoscopies, blood pressure screening, and cholesterol screening	100%, with no deductible and no co-payment	Not covered [1]
Emergency Room	You pay $150 co-payment per visit (waived if admitted); Plan pays 100% after co-payment	
Emergency Ambulance Services	You pay 10%; Plan pays 90% after deductible	You pay 30%; Plan pays 70% after deductible
Chiropractic Services/Spinal Manipulation	You pay a $5 co-payment; Plan pays 100% after co-payment Retirees pay a $25 co-payment	You pay a $5 co-payment; Plan pays 100% after co-payment Retirees pay a $25 co-payment
Treatment Limit	26 visits per calendar year combined	
Physical, Occupational, and Speech Therapy	You pay 10%; Plan pays 90% after deductible	You pay 30%; Plan pays 70% after deductible
Maximum Visits	60 combined visits per calendar year	
Second /Third Surgical Opinions	Plan pays 100%	
Inpatient Mental Health and Substance Use Disorder Treatment	You pay 10%; Plan pays 90% after deductible	You pay 30%; Plan pays 70% after deductible
Outpatient Mental Health and Substance Use Disorder Treatment, provider office visit and related diagnostic tests and procedures	You pay a $25 co-payment; Plan pays 100% after co-payment	You pay 30%; Plan pays 70% after deductible

[1] If no in-network provider is located within 25 miles of a Participant's or Dependent's primary residence or if the Participant or Dependent needs the care when he or she is more than 150 miles away from home and more than 25 miles from any in-network provider providing the type of care sought, then in-network benefit levels apply for out-of-network providers.

Benefit	In-Network	Out-of-Network[1]
Outpatient Mental Health and Substance Use Disorder Treatment other than provider office visit and related services	You pay 10%; Plan pays 90% after deductible	You pay 30%; Plan pays 70% after deductible
Durable Medical Equipment	You pay 10%; Plan pays 90% after deductible	You pay 30%; Plan pays 70% after deductible
Orthotics and Prosthetics	You pay 10%; Plan pays 90% after deductible	You pay 30%; Plan pays 70% after deductible
Hearing Aids, when medically necessary and prescribed by an audiologist or other doctor specializing in ear, nose, and throat (an ENT)	$250 co-payment then up to $2,600 per ear every 2 years	$500 co-payment then up to $2,600 per ear every 2 years
Prescription Drugs Retail (30-day supply)	You pay a $10 co-payment for generics. You pay a $25 co-payment for preferred brands. You pay a $40 co-payment for non-preferred brands.	
Mail Order (90-day supply)	You pay a $20 co-payment for generics. You pay a $45 co-payment for preferred brands. You pay a $75 co-payment for non-preferred brands.	

[1] If no in-network provider is located within 25 miles of a Participant's or Dependent's primary residence or if the Participant or Dependent needs the care when he or she is more than 150 miles away from home and more than 25 miles from any in-network provider providing the type of care sought, then in-network benefit levels apply for out-of-network providers.

Section 3.02 Schedule of Medical Benefits—Locals 321 and 577

The following chart highlights key features of the PPO plan provided to eligible Active and non-Medicare-eligible retired Participants and their Dependents participating in Local 321. Section 3.01 provides a chart, which highlights key features of the PPO plan provided to eligible Active and retired Participants and their Dependents participating in all Locals, except Local 321.

Comprehensive Medical Expense Benefit Local 321		
Benefit	**In-Network**	**Out-of-Network [1]**
Deductible Individual Family	 $900 $2,700	 $1,800 $3,600
Coinsurance	You pay 20%; Plan pays 80% after deductible	You pay 40%; Plan pays 60% after deductible

[1] If no in-network provider is located within 25 miles of a Participant's or Dependent's primary residence or if the Participant or Dependent needs the care when he or she is more than 150 miles away from home and more than 25 miles from any in-network provider providing the type of care sought, then in-network benefit levels apply for out-of-network providers.

Benefit	In-Network	Out-of-Network [1]
Annual Out-of-Pocket Maximum [2] Individual Family	 $3,800 $11,400	 $7,600 $15,200
Doctor Office Visits/Specialist Office Visits Covered services include the office visit, and related diagnostic tests and procedures (e.g., x-ray, lab, office surgery) whether rendered in a doctor's office, clinic or other facility not part of a hospital outpatient or inpatient department	You pay a $25 co-payment; Plan pays 100% after co-payment	You pay 40%; Plan pays 60% after deductible
Hospital Inpatient and Outpatient Services, including outpatient surgery, hospital urgent care facility, hospital testing center, and organ and tissue transplants	You pay 20%; Plan pays 80% after deductible	You pay 40%; Plan pays 60% after deductible
Home Health Care and Hospice	You pay 20%; Plan pays 80% after deductible	You pay 40%; Plan pays 60% after deductible
Maternity Care, Office Visits -- Covered services include the office visit, and related diagnostic tests and procedures (e.g., x-ray, lab, office surgery) whether rendered in a doctor's office, clinic or other facility not part of a hospital outpatient or inpatient department	You pay a $25 co-payment for first visit only if billed separately from the delivery fee for confirmation of the pregnancy	You pay 40%; Plan pays 60% after deductible
Skilled Nursing Facility (in lieu of inpatient hospital admission when approved by Plan. Semi-private room)	You pay 20%; Plan pays 80% after deductible	You pay 40%; Plan pays 60% after deductible
Admission Limitation	45 days per benefit period	
Preventive Care Services– Includes standard immunizations and those services recommended by the U.S. Preventive Services Task Force at the time the service is provided including, as appropriate for the age and gender of the individual, mammograms, colonoscopies, blood pressure screening, and cholesterol screening	100%, with no deductible and no co-payment	Not covered [1]

[1] If no in-network provider is located within 25 miles of a Participant's or Dependent's primary residence or if the Participant or Dependent needs the care when he or she is more than 150 miles away from home and more than 25 miles from any in-network provider providing the type of care sought, then in-network benefit levels apply for out-of-network providers.

[2] Deductibles and co-payments do not count toward the out-of-pocket maximum. However, co-insurance does count towards the out-of-pocket maximum.

Benefit	In-Network	Out-of-Network [1]
Emergency Room	You pay $150 co-payment per visit (waived if admitted); Plan pays 100% after co-payment	
Emergency Ambulance Services	You pay 20%; Plan pays 80% after deductible	You pay 40%; Plan pays 60% after deductible
Chiropractic Services/Spinal Manipulation	You pay 20%; Plan pays 80% after deductible	You pay 40%; Plan pays 60% after deductible
Treatment Limit	26 visits per calendar year	
Physical, Occupational, and Speech Therapy	You pay 20%; Plan pays 80% after deductible	You pay 40%; Plan pays 60% after deductible
Maximum Visits	60 combined visits per person per calendar year	
Second /Third Surgical Opinions	Plan pays 100%	
Inpatient Mental Health and Substance Use Disorder Treatment	You pay 20%; Plan pays 80% after deductible	You pay 40%; Plan pays 60% after deductible
Outpatient Mental Health and Substance Use Disorder Treatment, provider office visit and related diagnostic tests and procedures	You pay $25 co-payment; Plan pays 100% after co-payment	You pay 40%; Plan pays 60% after deductible
Outpatient Mental Health and Substance Use Disorder Treatment other than provider office visit and related services	You pay 20%; Plan pays 80% after deductible	You pay 40%; Plan pays 60% after deductible
Durable Medical Equipment	You pay 20%; Plan pays 80% after deductible	You pay 40%; Plan pays 60% after deductible
Orthotics and Prosthetics	You pay 20%; Plan pays 80% after deductible	You pay 40%; Plan pays 60% after deductible
Hearing Aids, when medically necessary and prescribed by an audiologist or other doctor specializing in ear, nose, and throat (an ENT)	$250 co-payment then up to $2,600 per ear every 2 years	$500 co-payment then up to $2,600 per ear every 2 years
Prescription Drugs		
Retail (30-day supply)	You pay a $10 co-payment for generics. You pay a $40 co-payment for preferred brands. You pay a $55 co-payment for non-preferred brands.	
Mail Order (90-day supply)	You pay a $20 co-payment for generics. You pay a $75 co-payment for preferred brands. You pay a $100 co-payment for non-preferred brands.	

[1] If no in-network provider is located within 25 miles of a Participant's or Dependent's primary residence or if the Participant or Dependent needs the care when he or she is more than 150 miles away from home and more than 25 miles from any in-network provider providing the type of care sought, then in-network benefit levels apply for out-of-network providers.

4. A new Section 10.02 (32) is added to read as follows:

(32) Prenatal testing to analyze fluid and tissue obtained as a result of amniocentesis or chronic villus sampling (CVS) in a covered pregnant female employee or spouse as follows:

- Regardless of pregnant participant's age, (tests performed via CVS or amniocentesis):
  - Cystic fibrosis
  - Sickle cell anemia
  - Down syndrome
  - Neural tube defects, including spina bifida
  - Hemophilia
- For pregnant participant's age 35 or older (tests performed via CVS or amniocentesis), in addition to the above:
  - Chromosomal microdeletions
  - Aneuploidy disorders (Trisomy 21 and monosomy)
  - Trisomy 9 and 16

If the prenatal tests are billed as a "panel" for several diseases at once and include tests that are covered and not covered, only the reasonable and customary amount for the covered tests will be allowed.

5. A new Section 10.04 (20) is added to read as follows:

(20) Charges for genetic testing, except to the extent such services are explicitly listed under Section 10.03.

* * *

IN WITNESS WHEREOF, this Amendment to the Iron Workers St. Louis District Council Welfare Plan was signed on behalf of the full board of Trustees on the 27th of April 2017.

Chairman

Co-Chairman

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