

**SHEET METAL WORKERS LOCAL 104 HEALTH CARE PLAN
(As revised January 2021)**

Amendment 26

Pursuant to the authority set forth in Article VII of the Agreement and Declaration of Trust, the Trustees hereby amend the Sheet Metal Workers Local 104 Health Care Plan as follows:

- 1. The “Continued Eligibility Based on Reciprocal Contributions” subsection of the “Bargaining Unit Members” under “Eligibility Rules” is revised to read as follows:**

Continued Eligibility Based on Reciprocal Contributions

Contributions you earn under another local union Collective Bargaining Agreement and paid to another health plan may be transferred to this Plan pursuant to a written reciprocity agreement. The local union where you earn contributions must notify the health plan for that jurisdiction that contributions made on your behalf are to be reciprocated to this Plan. There is usually a delay of at least 30 days before the Plan receives reciprocity contributions from other health plans. This may result in an interruption in coverage and possibly a COBRA notice depending on the number of hours in your Reserve Hour Bank.

When the hourly contribution rate being reciprocated to this Plan from other health plans is different than the hourly rate of contributions paid directly to this Plan under the Collective Bargaining Agreement in effect at the time of the contribution transfer, the hours credited to you under this Plan will be prorated. The reciprocated contributions will be prorated against the hourly contribution rate for this Plan under the Collective Bargaining Agreement in effect at the time of the contribution transfer without an allocation to Supplemental Unemployment Benefits, Supplemental Health Care Benefits, and the pooled Health Reimbursement Arrangement (i.e., the base health care rate only).

For example, if you work 150 hours in another local union jurisdiction where the hourly health plan contribution rate is \$10.00, and the current hourly contribution rate for this Plan is \$15.00 (not including an allocation to Supplemental Unemployment Benefits, Supplemental Health Care Benefits, or Health Reimbursement Arrangement) the hours will be prorated as follows:
 $\$10.00/\$15.00 = 66.6667\%$
 $150 \text{ hours} \times 66.6667\% = 100 \text{ hours credited to your Reserve Hour Bank}$

To stop contributions being reciprocated to this Plan, you must change your membership from SMART, Sheet Metal Workers Local Union 104 to another local union.

Reciprocal Contributions Proration for District 2 Only

If you work under a Collective Bargaining Agreement with SMART Local 104, District 2, contributions made on your behalf will be reciprocated to this Plan, and your contributions will be prorated based on the full District 1 health care rate in effect at that time under the Collective Bargaining Agreement, including an allocation to Supplemental Unemployment Benefits, Supplemental Health Care Benefits, and the pooled Health Reimbursement Arrangement.

For example, if you work 150 hours in District 2 where the hourly health plan contribution rate is \$15.00, and the current hourly contribution rate for this Plan is \$17.00 (\$15.00 as base health care rate, \$1.50 for Supplemental Unemployment Benefits and Supplemental Health Care Benefits, and \$1.50 for pooled Health Reimbursement Arrangement) the hours will be prorated as follows:

$$\$15.00/\$17.00 = 88.2353\%$$

$$150 \text{ hours} \times 88.2353\% = 132.35 \text{ hours credited to your Reserve Hour Bank}$$

You will also earn Supplemental Unemployment Benefits and Supplemental Health Care Benefits based on your prorated contributions.

Additionally, the hourly Health Reimbursement Arrangement contribution made on your behalf under the Collective Bargaining Agreement with SMART Local 104, District 2, will be reciprocated to your Health Reimbursement Arrangement Account under this Plan.

2. The “Applying for Continued Coverage While Disabled” subsection of the “If You Become Disabled” under “Continuing Plan Coverage” is revised to read as follows:

Applying for Continued Coverage While Disabled

When you apply for continued coverage, you must submit proof of your disability. This proof must include: (a) disability dates (beginning and ending, including any updated disability extensions from your doctor), (b) diagnosis or ICDA code, (c) the signature of a Physician holding a Doctor of Medicine (M.D.) degree. Continued proof of your disability will be required by the Trust Fund Office, and the Plan reserves the right to request certification of your disability in writing from two (2) of your treating physicians to be certified as disabled.

Once you have used all available no-cost coverage, you **must** elect to extend your coverage during the first month your Reserve Hour Bank runs out in order to continue coverage while you are disabled by paying for coverage that starts that month. From then on, you must continue paying by the 20th of the month for the extended coverage.

There is no subsidized coverage during disability if you are covered under a Subscription Agreement with the Plan. Call the Trust Fund Office for more information.

You must be eligible for covered employment once disability ends to continue coverage under the Plan.

Residential Utility Workers and Maintenance Service Technicians are not eligible for this benefit.

3. The “Retiree Health Plan” section is revised to read as follows:

Retiree Health Plan

Residential Utility Workers and Maintenance Service Technicians are not eligible for the Retiree Health Plan.

When you retire and are no longer eligible for Active coverage under the Plan, **you must first exhaust your Reserve Hour Bank before electing coverage under the Retiree Health Plan.** Your Reserve Hour Bank is exhausted when the hours remaining in your Hour Bank are less than the hours necessary to provide further eligibility under the Plan.

The Trustees have established the Retiree Health Plan of the Sheet Metal Workers Local 104 Health Care Plan on the basis that the employer contributions for active employees will, if continued, maintain this Plan for retirees. At the present time, eligible retirees pay only part of the cost for Retiree Plan benefits. The cost of retiree benefits is subsidized from employer contributions earned by active employees. The benefits provided by this Plan can be paid only to the extent that the Trust has available adequate resources for those payments. The Trustees have discretion to reduce benefits of this Plan. The Trustees have discretion to reduce or eliminate the subsidy for benefit coverage to the retirees. The Trustees have discretion to reserve the right to use Trust reserves for benefit coverage for active employees or retirees. The retiree coverage is not a vested benefit and while reserves of the Plan are being accumulated to help underwrite this benefit, those reserves may be utilized for other benefits at the discretion of the Trustees.

No participating employer has any liability, directly or indirectly, to provide the benefits established by this Plan beyond the obligation of the participating employer to make contributions as stipulated in the Collective Bargaining Agreement or the Trust Agreement. In the event that at any time the Trust does not have sufficient assets to permit continued payments under this Plan, nothing contained in this Plan or the Trust Agreement shall be construed as obligating any participating employer to make benefit payments or contributions other than the contributions for which the participating employer may be obligated by his or her Collective Bargaining Agreement or Trust Agreement. Likewise, there shall be no liability upon the Trustees, individually or collectively, or upon the contractor, employer associations or local union to provide the benefits established by this Plan if it does not have assets to make such benefit payments or should the Trustees in their discretion utilize Plan assets for benefits other than subsidizing the Retiree Health Plan.

Retiree Health Plan benefits include medical, dental, prescription drug, vision care, and death and accidental death and dismemberment benefits for you and your eligible dependent(s). Please note that prior benefit schedules 2, 4 and 5 are closed to new retirees. Once a retiree elects a schedule of benefits, changes are not permitted.

You must have continuous coverage under the Active Plan prior to applying for Retiree Health Plan coverage in order to qualify, unless you receive a waiver from the Board of Trustees.

MEDICARE

Medicare benefits are not automatic; you must apply for them in order to be covered. Medicare benefits are available with two part coverage: Part A is free of charge and provides hospital benefits; Part B provides supplemental medical insurance and you are charged a monthly premium. This Plan coordinates benefits with Medicare as if you are covered under both Medicare Part A and Part B. This means you must enroll in Medicare, **for both Part A and Part B**, as soon as you are eligible for Medicare. **If you do not enroll in Medicare (Part A and Part B), the Plan will not cover the portion of the expenses that Medicare would have paid. You must notify the Trust Fund Office immediately upon becoming eligible for Medicare. If you have a dependent that is eligible for Medicare, he or she must enroll in both Part A and Part B also.**

In order to get full protection, you MUST enroll for both Part A and Part B of Medicare before you or your dependent becomes eligible for Medicare.

For more details about Medicare, contact your local Social Security Office.

ELIGIBILITY RULES FOR RETIREE PLAN BENEFITS

Retired employees of participating employers who contribute to the Sheet Metal Workers Local 104 Health Care Plan are eligible for benefits under the Retiree Health Plan. Eligible dependents are described on page 9.

You will be considered a retired employee and eligible for coverage under the Plan if you meet all of the following requirements:

1. You are age 52 or over.
2. You have “completely retired” from the Sheet Metal Trade. PLEASE NOTE: The effective date of your retirement under the Sheet Metal Workers Pension Plan of Northern California shall be the date you have “completely retired” from the Sheet Metal Trade.

“Completely retired” is defined as-terminating Covered Employment and not engaging in non-covered sheet metal service.

3. You meet the 60/84 test as follows:

During the 84 months prior to the date you are “completely retired”, you had 60 months of active eligibility including any of the following:

- Hour bank
- Disability extension
- Subsidized self-pay
- Supplemental Health Care (SHC) payments.

Note: If the date you “completely retire” is deemed to be retroactive, if for example, you get a retroactive Social Security Disability award, the retroactive period will not count toward the 60/84 test, and retiree premiums will be due for the retroactive period, excluding

any period of coverage provided by your Hour Bank. The Trustees may waive this provision upon a showing of good cause, determined solely within their discretion.

If, at the time you retire, you are not eligible for a pension benefit from the ~~Northern California~~ Sheet Metal Workers Pension Plan of Northern California, the 60/84 test will start effective the first of the month following the month you last worked in covered employment. Your first retiree premium will be due the first of the month following the month you last worked in covered employment, or the first of the month following the month your Hour Bank runs out, whichever is later.

Any time during which you are on COBRA continuation coverage does not count toward your 60 months.

Exceptions:

Shipyard Employment: The Plan will allow credit for up to twelve (12) months of employment in the shipyards to be applied to the 60/84 test, under the following conditions:

- Such employment would be recognized for credit towards retirement benefits under the Sheet Metal Workers of Northern California Pension Plan;
- You are not eligible for retiree coverage under the shipyard plan.

4. You maintain your membership in Local 104 of the Sheet Metal Workers International Association.
5. You apply for retiree coverage no later than the date you retire and begin making payments as soon as you are eligible for benefits. Upon application, you may temporarily opt out of the Retiree Health Plan and postpone making payments for you and/or your eligible dependents under the following circumstances. Note that Medicare does not constitute other group coverage for this purpose.

(a) At Retirement, You are Covered Under Your Spouse's Group Health Plan. At retirement, you may elect to temporarily opt out of the Retiree Health Plan if you are covered under your spouse's group health plan. You must inform this Plan in writing at the time of retirement that you are declining coverage because you are covered under your spouse's plan. Once the other coverage ceases, you may opt back in to the Retiree Health Plan if you can prove you had continuous coverage from the date of your retirement and you begin making payments to this Plan within 30 days of losing the other coverage.

(b) During Retirement you Marry or Your Spouse Obtains Other Group Coverage. If during your retirement you marry or your spouse obtains other group coverage, you and/or your spouse each have a 'one-time' opportunity to opt out of the Retiree Health Plan. You must inform this Plan in writing at the time you opt out that you are declining coverage because you are covered under your spouse's plan. Once the other coverage ceases, you may opt back into the Retiree Health Plan if you can prove you had continuous coverage from the date you opted out and you begin making payments to this Plan within 30 days of losing the other coverage.

(c) Your Spouse Declines Coverage because He/She is Enrolled in His/Her Own Group Plan. If at the time of your retirement or the time of marriage, whichever is later, your spouse is enrolled in his/her own group health plan or other equivalent health care coverage, he/she may decline coverage in the Retiree Health Plan. Your spouse must inform this Plan in writing at the time of declining coverage that he/she is declining coverage because of enrollment in his/her own group health plan or other equivalent health care coverage. Once the other coverage ceases, he/she may be enrolled into this Plan if he/she can prove he/she had continuous coverage from the date of your retirement or marriage, whichever is later, and you begin making payments to this Plan within 30 days of the date your spouse lost his/her other coverage.

6. Your first payment for Plan coverage will be due during the first month after which your active coverage ends after your Hour Bank runs out. After that time, regular monthly payments must be received by the Trust Fund Office no later than the 20th day of the month preceding the month of coverage. If you apply for retiree coverage after 12-months of self-pay due to unemployment or disability, your first payment for retiree coverage will still be due the date after your Hour Bank runs out, **and there will be a retroactive adjustment made to the premium if there is any difference between the retiree rate and the self-pay rate, including any payments made on your behalf from either the Supplemental Unemployment or Supplemental Health Care for any period such payments were made after the effective date of your retirement.**

If you do not pay the required monthly payment by the 20th day of the month preceding the month of coverage, your coverage will be terminated effective the 1st of the month for which payment was not received. However, Medicare-eligible retirees and dependents will be provided with a grace period of two (2) calendar months and notice that is compliant with the requirements of the Centers for Medicare and Medicaid Services (CMS). If the required monthly payments are not paid by the end of the grace period for all amounts owed (including grace period months, if then due), then the retiree and/or dependent(s) coverage will be terminated the first of the month following the end of the grace period.

7. The Board of Trustees has the discretion to waive any and all of the above criteria.

For information regarding when coverage ends, please refer to page 11.

RETIRED OWNER/MANAGERS

The Plan will determine retiree eligibility for Plan participants who were previously covered as Owner/Managers at the last time the participant was eligible through Owner/Member and/or Collective Bargaining Agreement participation, and extend retiree coverage if the participant would have met the requirement set forth on page 78, item #2, and satisfied the remaining requirements for retiree status at the time of application when the participant was a bargaining employee. Owner/Managers are required to contribute at the unsubsidized rate.

ELIGIBLE DEPENDENTS

Please refer to page 9 for a definition of eligible dependents.

You must enroll your eligible dependents within 90 days of the date you acquire a new dependent, such as through marriage, birth or adoption.

Please refer to page XX for when coverage will end for a dependent.

RETIREE SUBSIDIZED SELF PAYMENT RATES

Retiree rates are established by the Board of Trustees and may change from time to time. The Trustees have discretion to reduce or eliminate the subsidy.

If you elect to continue coverage as a retiree and you are receiving a pension from the Sheet Metal Workers of Northern California Pension Trust Fund, your payments to this Plan may be deducted from your monthly pension checks.

IF YOU BECOME DISABLED PRIOR TO RETIREMENT

If you are totally or partially disabled as defined below and you meet the eligibility requirements for retired employees above (except the requirement that you be age 52 or older), you can continue Plan coverage as a retiree. You must enroll in Medicare Part A and Part B as soon as you become eligible and provide the Fund Office with a copy of your Medicare card.

To be considered “totally disabled”, you must be:

1. Entitled to disability benefits under Social Security, or you would be entitled if you had sufficient quarters of disability, and
2. Unable to engage in any work earning more than the gainful activity level as deemed by Social Security. You must report any income in excess of the gainful activity level to the Trust Fund Office by each July 15 and January 15. This amount is set by Social Security and may change from time to time.

You are considered “partially disabled” if you have a physical or mental condition from an injury, disease or mental disorder, which makes you incapable of working in the sheet metal industry for the remainder of your life.

You must apply for retiree coverage no later than the date you exhaust your reserve Hour Bank. You may postpone commencement of coverage as described in the Retiree Eligibility Rules.

The Trust Fund Office will require you to submit proof of your continuing disability from time to time. If you are under age 52 and you are no longer totally or partially disabled, your coverage will end. However, if you return to work on a trial basis (as allowed by Social Security) you may continue Plan coverage as a retiree until you regain eligibility as an active employee.

IF YOU RETURN TO WORK AFTER RETIREMENT

If you are retired but are thinking of returning to work, you should request an advance decision from the Trustees on whether your proposed employment will adversely affect your eligibility for retiree coverage. Such requests should be made in writing and sent to the Trust Fund Office. Failure to notify the Trust Fund Office of your return to work will result in termination of your retiree health care coverage.

If you return to work after retirement, your coverage under the Retiree Health Plan will be impacted as follows:

Part-Time Instructor:

If you work less than 40 hours per month as a part-time instructor for a Joint Apprenticeship Committee in the sheet metal industry, or other apprenticeship or pre-apprenticeship program approved by the Board of Trustees, you may continue to participate in the Retiree Health Plan at the subsidized retiree rate.

Non-Bargaining Unit Position:

If you return to work in the sheet metal industry in a position not covered by the Collective Bargaining Agreement (non-bargaining unit position), including “Employment Beneficial to the Industry” under the Sheet Metal Workers of Northern California Pension Plan, you may continue to participate in the Retiree Health ~~Care~~ Plan at unsubsidized retiree rates.

Bargaining Unit Position:

If You are Age 65 or Older and Work Less Than 40 Hours per Month

If you return to work after retirement, if you are age 65 or older and work less than 40 hours per month in any type of job over which the Sheet Metal Workers International Association has jurisdiction, including all government agency work, or in which your employer is a sponsor of the Plan, you will still be considered a retiree in terms of how you are covered by the Plan. The hours you work will go into your Reserve Hour Bank initially and be stored for use later on.

The following January 1, your status will switch and you will be eligible for benefits under the Plan as an active employee. Then, for as many months as the hours in your Reserve Hour Bank allow, you will be covered under the Plan as an active employee under the schedule of benefits for which contributions were made on your behalf. During this period, you will *not* have to make payments to the Plan since you already have eligibility based on your Reserve Hour Bank. Medicare is secondary on claims you and your covered dependents who are eligible for Medicare incur while you are covered as an active employee.

After your Reserve Hour Bank drops below the minimum required hours, you will revert to retiree coverage status and be covered by the benefits schedule you chose upon retiring. Any remaining hours in your Reserve Hour Bank will be saved for the next year. Medicare is primary on claims you and your covered dependents eligible for Medicare incur while you are covered as a retiree.

If You are Age 65 or Older and Work More Than 40 Hours per Month

If you return to work after retirement, if you are age 65 or older and you work more than 40 hours per month, you can continue to pay for retiree coverage at the subsidized rate until you reestablish eligibility as an active employee. Your retiree coverage will be reinstated once you stop working in Covered Employment.

If You are Younger than Age 65

If you return to work after retirement before age 65, you can continue to pay for retiree coverage at the subsidized rate until you reestablish eligibility as an active employee. Your retiree coverage will be reinstated once you stop working in the sheet metal industry.

Non-Covered Sheet Metal Service

If you return to work in non-covered sheet metal service, your retiree coverage will be terminated immediately. Your retiree coverage may be reinstated only with approval of the Board of Trustees.

4. The “Indemnity Plan Participants Medicare-Eligible Retirees and Dependents” subsection under “Prescription Drug Benefits” is revised to read as follows:

INDEMNITY PLAN PARTICIPANTS
MEDICARE-ELIGIBLE RETIREES AND DEPENDENTS

Medicare Retirees and Dependents: If you are a Medicare-eligible retiree, you and your other Medicare-eligible family members do not need to enroll in Medicare Part D for prescription drug coverage if you enroll in the Sheet Metal Workers Local 104 Health Care Plan Medicare Prescription Drug Plan (PDP), administered by Optum Rx. You must notify the Plan when you become eligible for Medicare so that you can be enrolled in the Sheet Metal Workers Local 104 Health Care Plan Medicare Prescription Drug Plan (PDP), administered by Optum Rx. You must enroll in Medicare Parts A and B. The prescription drug benefits you currently receive under the Sheet Metal Workers Local 104 Health Care Plan are as good as or better than the standard Medicare Part D prescription drug coverage. Enrolling in Part D prescription drug coverage will increase your overall cost without giving you better benefits than the Plan provides, and might actually jeopardize your benefits under the Plan. As long as you have prescription drug coverage under the Plan, you are considered to have “credible coverage”; therefore, if at some later date you choose to enroll in Medicare Part D, you will not be charged a late penalty for delayed enrollment.

Prescription Drug Benefits: Sheet Metal Workers Local 104 Health Care Plan Medicare Prescription Drug Plan

Prescription drugs for Medicare-eligible Retirees and Dependents are provided under the Sheet Metal Workers Local 104 Health Care Plan Medicare Prescription Drug Program that is administered by Optum Rx. This is an Employer Group Waiver Plan (EGWP) under Medicare Parts C and D. Notwithstanding the benefits or exclusions of the Indemnity Plan, this Sheet Metal Workers Local 104 Health Care Plan Medicare Prescription Drug Program shall comply with and provide benefits consistent with Medicare requirements for EGWPs. You will receive coverage information, including a summary of benefits, and your prescription drug ID cards directly from Optum Rx.

You can get your prescriptions filled by a pharmacy that is in the Optum Rx network, either from your local retail pharmacy or through a prescription mail-order service. You will pay the same cost-sharing amount (copayment and/or coinsurance) at any network pharmacy.

ANNUAL DEDUCTIBLE: \$0

OUT-OF-POCKET MAXIMUM: \$2,500 per individual. Your annual Out-of-Pocket Maximum includes medical and prescription drug expenses that count towards the Out-of-Pocket Maximum. Non-Preferred Brand Drug copayments and coinsurance do not count towards your Out-of-Pocket Maximum. For medical expenses that do not count towards your Out-of-Pocket, see “OUT-OF-POCKET MAXIMUM” under the “Medical Benefits” section of this Summary Plan Description.

COPAYMENTS AND COINSURANCE:

<u>Covered Prescription Drug</u>	<u>Retail Pharmacy (up to 30 Day Supply)</u>	<u>Retail Pharmacy (31 – 90 Day Supply)</u>	<u>Home Delivery (up to 90 Day Supply)</u>
Generic Drugs	\$15 Copayment	\$30 Copayment	\$30 Copayment
Preferred Brand Drugs	25% Copayment; \$15 Copayment minimum and \$50 Copayment maximum	50% Copayment; \$30 Copayment minimum and \$100 Copayment maximum	50% Copayment; \$30 Copayment minimum and \$100 Copayment maximum
Non-Preferred Brand Drugs <i>Copayment does not apply to the Out-of-Pocket Maximum</i>	25% Copayment; \$15 Copayment minimum and no Copayment maximum	50% Copayment; \$30 Copayment minimum and no Copayment maximum	50% Copayment; \$30 Copayment minimum and no Copayment maximum
Insulin and Diabetes Maintenance Medications	\$0	\$0	\$0

Medicare Part B and Part D Excluded Drugs: The Plan offers supplemental coverage on some prescription drugs not normally covered under Medicare Part D and/or Part B. To obtain a list of all supplemental coverage prescription drugs covered, please contact OptumRx.

Coverage Limitations:

- **Prior Authorization:** Some drugs require your provider to get prior authorization (approval) from Optum Rx before the drug will be covered.
- **Step Therapy:** You may be required to try one drug to treat your condition before the Plan will cover another drug for that condition.
- **Quantity Limitations:** There are quantity limits on certain drugs, which means that you can only get a certain amount of a drug within a specified timeframe.

Insulin and Diabetes Maintenance Medications: The Plan covers medically necessary medications, devices, and supplies used for the treatment of diabetes with \$0 copayment. This includes the following categories of products:

- Medications
 - Alpha-Glucosidase Inhibitors
 - Antidiabetic – Amylin Analogs
 - Antidiabetic – Cellular Therapy

- Antidiabetic – Dopamine Receptor Agonists
- Antidiabetic Combinations
- Biguanides
- Dextrose
- Diazoxide Oral Suspension
- Dipeptidyl Peptidase-4 Inhibitors
- GLP-1
- Glucagon
- Glucose
- Insulin
- Insulin Sensitizing Agents
- Korlym
- Meglitinide Analogues
- Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors
- Sulfonylureas
- Devices
 - Continuous Glucose Meters
 - Glucose Meters
 - Injection Devices
 - Insulin Infusion Pump – both Pump with Tubing and Tubeless Pumps (coverage includes kit, reservoirs, device and medically necessary accessories and supplies)
 - Lancing Device
- Supplies
 - Alcohol Pads
 - Control Solution
 - Insulin Syringe
 - Lancets
 - Pen Needle
 - Test Strips
 - Urine Test Strips
 - Miscellaneous Medically Necessary Supplies

A list of all products currently covered with a \$0 copayment can be obtained from the Trust Fund Office.

Medication Therapy Management (MTM) Program: This is a free service offered by OptumRx. The program helps to make sure you are using drugs that work best to treat your medical condition. It can also help OptumRx identify possible medication errors. If you meet the criteria, Optum Rx will automatically enroll you in the program and send you information. If you do not wish to participate, please let OptumRx know and you will be removed from the program.

M3P Program: The Medicare Prescription Payment Plan (“M3P program”) is a new payment option within Medicare Part D that allows beneficiaries to spread out their prescription drug costs throughout the year instead of paying the full amount at the pharmacy. It’s designed to make medications more affordable by avoiding large upfront costs, particularly those with high drug expenses. The program is available at no cost to all individuals enrolled in the Sheet Metal

Workers Local 104 Health Care Plan Medicare Prescription Drug Plan (PDP), administered by OptumRx. Instead of paying at the pharmacy, members will receive a monthly bill from the Plan via OptumRx for their prescription costs. Participation is voluntary, but you must opt-in by enrolling with OptumRx. Enrollment in the program can be done at any time during the year by contacting OptumRx or through www.optumrx.com.

Out-of-Network Pharmacy: If you have prescriptions filled by an out-of-network pharmacy, you must pay the full amount yourself and file a claim with OptumRx for reimbursement. If the claim is not approved, there will be no reimbursement. If the claim is approved, you will be responsible for your share of the cost (copayment and/or coinsurance described above), plus the difference between the lower network cost and the amount the pharmacy charged. This difference will not count towards your annual Out-of-Pocket Maximum.

Drug Coverage Determinations/Exception Requests: You have the right to request a coverage determination, which is a decision made by the Plan about a drug that you believe should be covered. You may also ask for an exception if you believe you need a drug that is not on the list of covered drugs or that you believe should be covered at a lower out-of-pocket cost. To make a request, your prescriber should contact OptumRx.

Address: OptumRx, Prior Authorization Department
P.O. Box 2975
Mission, KS 66201
Phone: 1-866-235-3171, TTY 711
24 hours a day, 7 days a week
Fax: 1-844-403-1028

Once a request is submitted, you will receive a decision from OptumRx within 72 hours for a standard request, or 24 hours if the request has been expedited. Your request will be expedited if OptumRx determines, or your prescriber informs OptumRx, that your life, health, or ability to regain maximum function may be seriously jeopardized by waiting for a standard request.

Appeals: If your coverage for a prescription drug is denied, you have the right to appeal that decision by asking for a review from OptumRx. Your appeal request must be submitted within 60 calendar days from the date of the written decision on your first coverage determination or exception request.

Address: OptumRx, Prior Authorization Department, c/o Appeals Coordinator
P.O. Box 2975
Mission, KS 66201
Phone: 1-866-235-3171, TTY 711
24 hours a day, 7 days a week
Fax: 1-844-403-1028

You may also submit an appeal to the Board of Trustees of the Plan. The Plan's Claims and Appeals Procedures begin on page ___ of this Summary Plan Description.

Optum Rx Member Services:

Phone (toll-free): 1-855-235-1405
TTY users: 711
Hours of Operation: Monday – Friday, 8 a.m. – 8 p.m. PST, except holidays
Website: optumrx.com

Income Related Monthly Adjustment Amount (IRMAA): This is an additional premium amount that you may be billed for by the Social Security Administration if your modified adjusted gross income as reported on your IRS tax return for 2 years ago is above a certain amount. For 2025, if your income is \$106,000 or more for an individual in 2023 (or married individuals filing separately) or \$212,000 or more for married couples in 2023, you must pay IRMAA in 2025 directly to the government for your Medicare Part D coverage. The income limits are adjusted annually. You can find the current IRMAA limits at <https://www.cms.gov/about-cms/contact/newsroom>. To maintain your coverage, if you are billed for IRMAA, you must pay it.

5. The definition of “Provider” is revised to read as follows:

PROVIDER

Physician, hospital, or other licensed health care professional or licensed health facility. A non-exhaustive list includes:

Practitioners:

1. A licensed Medical Doctor (M.D.)
2. A licensed Doctor of Osteopathy (D.O.)
3. A Chiropractic Doctor (DC) (under certain limited conditions).
4. A Doctor of Medical Dentistry (D.M.D.)
5. A Doctor of Dental Surgery (D.D.S.)
6. A Doctor of Podiatry (D.P.M.)
7. A Physical Therapist or Occupational Therapist or Speech Therapist
8. A Psychologist (Ph.D.)
9. A Master of Social Work (L.C.S.W., M.S.W., and M.F.C.C.)
10. An Ophthalmologist (M.D.) or an Optometrist
11. A Certified Nurse Anesthetist
12. A Registered Nurse as First Assistant (R.N.F.A.), under the supervision of a Medical Doctor
13. A Physician Assistant (P.A.)
14. A licensed Midwife
15. A licensed Denturist
16. A Nurse Practitioner (N.P., F.N.P)
17. A Pharmacist

A Provider does not include a person who lives in your home or who is related to you by blood or marriage.

Facilities:

1. Clinic or medical office
2. Health Care Facilities
3. Home Health Care
4. Hospitals

5. Independent Free Standing Emergency Department
6. Long term care and skilled nursing facilities
7. Outpatient Surgical Center
8. Pharmacy
9. Telehealth or telemedicine
10. Urgent care facility

This Amendment 26 was adopted by the Board of Trustees on March 17, 2026. The Chairman and Co-Chairman were authorized by the Board of Trustees to execute this Amendment on their behalf. This Amendment 26 may be executed in counterparts, each of which shall be deemed to be an original, but all of which together shall constitute one and the same Amendment 26.

Signed by:

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Chairman

Date: 3/18/2026

DocuSigned by:

B33424A5754248C...

Co-Chairman

Date: 3/18/2026