SUMMARY OF MATERIAL MODIFICATION TO THE DISTRICT NO. 9, INTERNATIONAL ASSOCIATION OF MACHINISTS AND AEROSPACE WORKERS WELFARE PLAN

The following is a summary of changes to the **C3GW** Plan of the District No. 9, International Association of Machinists and Aerospace Workers Welfare Plan (the "Plan") that the Trustees of the District No. 9, International Association of Machinists and Aerospace Workers Welfare Plan have recently adopted. Please keep this notice with your copy of the Summary Plan Description ("SPD") for future reference.

This summary only provides information regarding the changes that have been made to the Plans and does not provide all of the information that may be relevant to a particular provision. For more information concerning the provisions addressed by this summary, you should consult your SPD booklet and previous summaries of material modification.

EFFECTIVE JANUARY 1, 2021

The Trustees of the District No. 9, International Association of Machinists and Aerospace Workers Welfare Plan – C3GW ("Plan") hereby adopt this clarifying amendment. The amendment corrects scrivener's errors in the Plan document dated January 1, 2021. The changes to the C3GW plan set forth below are effective January 1, 2021:

1. The heading **4. Proof of Status as an Eligible Dependent** will be added to the Table of Contents under Section 3.B and on page 11 immediately after Section 3.B.3.b.

2. Section 8.F.29 is deleted in its entirety.

3. Section 8.F.8 of the SPD is replaced with the following:

   Charges for care, treatment, or surgery on the teeth, gums or alveolar process, or dentures, appliances, or supplies used in such care or treatment, <u>except</u> the Plan will pay the hospital charges if the covered individual is admitted to a hospital while receiving such treatment and will pay dental charges arising out of an accidental injury as set forth above at Section 8E10 of this Booklet.

4. Section 8.G.1.b(2) is replaced with the following:

   (2) <u>Co-Payment and Out-of-Pocket Amounts</u>. There is a 20% co-payment, up to a $150.00 maximum per month, for each Specialty Drug. There is also a separate annual $3,250.00 maximum for all Specialty Drugs combined. This means that after you have paid $3,250.00 in co-payments for Specialty Drugs during a calendar year, for the rest of the calendar year the Plan will cover 100% of the allowable cost as established by

the PBM. Please note, the amounts you pay for Specialty Drugs will not be included in determining whether you have reached the annual out-of-pocket maximum that applies to other Major Medical Benefits under the Plan.

After you have received $500,000.00 in Specialty Drug benefits, the co-payment increases to 50% for all Specialty Drug benefits you receive beyond $500,000.00, and the monthly and annual out-of-pocket limits no longer apply.

*The Plan includes all amounts incurred for Specialty Drugs in calculating the $500,000, regardless of where obtained or administered, except for Specialty Drugs administered at an in-patient facility.

3rd AMENDMENT TO THE DISTRICT NO. 9, INTERNATIONAL ASSOCIATION OF MACHINISTS AND AEROSPACE WORKERS WELFARE PLAN

The Trustees of the District No. 9, International Association of Machinists and Aerospace Workers Welfare Plan ("Plan") hereby adopt the following amendment to the C3GW Plan:

1. Effective January 1, 2021, the following scrivener's errors are corrected;

    a. The references to Sections 13B1 and 13B1c in Section 11B2 are changed to Sections 11B1 and 11B1c.
    b. The reference to Section 14H in Sections 1B, 8A4, 8B, 8G1a1 and 8G1a9 is changed to Section 12H.
    c. The reference to Section 13G on the Schedule of Benefits under "Important Note" is changed to 11D.

2. Effective January 1, 2022, the following changes are made:

    a. Section 1J is replaced with the following:

        You may also be able to reduce the cost of your medical care by taking advantage of other cost saving features of the Plan. If you need long-term maintenance prescription drugs, you should use the mail-in drug program described in Section 8G1 of this Booklet. If you need certain Specialty Drugs, you should enroll in the SaveonSP program described in Section 8G1b2(c) of this Booklet. Also, please see Section 8D3 of this Booklet with reference to pre-admission testing and outpatient surgeries.

    b. Section 8C is replaced with the following:

        In addition to saving money by using Network providers and by complying with the pre-certification and utilization review requirements, you may also be able to reduce the cost of your medical care by taking advantage of other cost saving features of the plan. If you need long-term maintenance prescription drugs, you should use the mail-in drug program described in Section 8G1 of this Booklet. If you need certain Specialty Drugs, you should enroll in the SaveonSP program described in Section 8G1b2(c) of this Booklet. Also, please see Section 8D3 of this Booklet with reference to pre-admission testing and outpatient surgeries.

    c. Section 8G1b2 is replaced with the following:

        (2) Co-Payment and Out-of-Pocket Amounts. Specialty Drugs will be covered under the prescription drug benefit as follows:

            (a) Except as set out in Section 8G1b2c, there is a 20% co-payment, up to a $150.00 maximum per month, for each Specialty Drug. There is also a separate annual $3,250.00 maximum for all Specialty Drugs

combined. This means that after you have paid out-of-pocket $3,250.00 in co-payments for Specialty Drugs during a calendar year, for the rest of the calendar year the Plan will cover 100% of the allowable cost as established by the PBM. Please note, the amounts you pay for Specialty Drugs will not be included in determining whether you have reached the annual out-of-pocket maximum that applies to other Major Medical Benefits under the Plan.

(b) In applying out-of-pocket maximums in connection with Specialty Drugs, the Plan looks only at expenses that are Essential Health Benefits. For purposes of this provision, out-of-pocket expenses only include amounts actually paid by a Covered Individual as a deductible, co-pay, and co-insurance after application of any secondary insurance or third-party payment (including co-pay assistance). Coupons, co-pay assistance and other forms of financial assistance, and any other amounts not paid out of the participant's or dependent's "pocket" are not considered by or accounted for under the Plan as out-of-pocket expenses.

(c) The Plan has adopted an Essential Health Benefit benchmark that identifies which Specialty Drugs are Essential Health Benefits and which are not. This benchmark is administered by Save On SP, LLC (SaveonSP) If you are taking a medication that is on the list of Non-Essential Health Benefit Specialty Drugs, a copy of which is available through the Fund Office, your payment share will depend on (a) the medication you are prescribed and (b) your enrollment status in the SaveonSP program.

- Once you enroll in the SaveonSP program, your co-insurance will be $0.
- Until you enroll in the SaveonSP program, you will be responsible for a 30% co-insurance amount. This co-insurance amount will not count towards your deductible or out-of-pocket maximums.

When you enroll in the SaveonSP program, SaveonSP will work with you to make sure you are enrolled for the appropriate third-party assistance for timely processing of prescriptions. You will pay nothing if you have enrolled in SaveonSP.

** Coverage by the Plan and access to the SaveonSP assistance program require that the prescription be medically necessary and appropriate and that, where necessary, prior authorization has been provided.

d. Section 8G1b3 is deleted in its entirety.

e. A new Section 11C2f is added as follows:

f. Prescription Drug Claims and Appeals

Prescription Drug benefit claims and appeals will be processed generally in accordance with the same procedures that apply to medical benefit claims under Sections 11C1 and 11C2, above, except that the PBM will make the initial determination and will resolve appeals regarding prescription drug benefits. The PBM has procedures for reviewing appeals of denied prescription drug claims that are generally consistent with the procedures described in Section 11C2 above. In the event your claim for a prescription drug benefit is denied, the PBM will advise you of its appeal procedures.

Please contact the Plan Office at (314) 739-6442 if you have any questions.

SUMMARY OF MATERIAL MODIFICATION TO THE
DISTRICT NO. 9, INTERNATIONAL ASSOCIATION OF MACHINISTS AND AEROSPACE WORKERS WELFARE PLAN

The following is a summary of changes to the C3GW Plan of the District No. 9, International Association of Machinists and Aerospace Workers Welfare Plan ("Plan") that the Trustees of the Plan adopted effective January 15, 2022. Please keep this notice with your copy of the Summary Plan Description ("SPD") for future reference.

This summary only provides information regarding the changes that have been made to the Plan and does not provide all of the information that may be relevant to a particular provision. For more information concerning the provisions addressed by this summary, you should consult your SPD booklet and previous summaries of material modification.

The following new item 10 is added to Section 8.G.1.a:

10. Coverage Of Over-The-Counter COVID Tests

    Effective January 15, 2022 and through the end of the COVID-19 Public Health Emergency as declared by the U.S. Department of Health and Human Services, Covered Individuals may obtain up to eight over-the-counter COVID tests per 30-day period. Tests may be obtained at any pharmacy participating in the retail network by showing your prescription drug card. Tests may also be obtained by contacting the mail-order program at the number provided on your prescription drug card.

    If you use a non-network pharmacy to obtain the covered tests, you must pay the full cost and submit a claim form for reimbursement to the pharmacy benefit manager at the address provided in Section 14.H. You will receive reimbursement for each individual covered test in an amount equal to the lesser of (i) the amount you paid for the test or (2) $12.00. In order to receive reimbursement, you must submit such documentation as required by the Trustees.

    COVID tests purchased for employment purposes are not covered under this benefit.

Please contact the Plan Office at (314) 739-6442 if you have any questions.

SUMMARY OF MATERIAL MODIFICATION TO THE
DISTRICT NO. 9, INTERNATIONAL ASSOCIATION OF MACHINISTS AND AEROSPACE WORKERS WELFARE PLAN

The following is a summary of changes to the C3GW Plan of the District No. 9, International Association of Machinists and Aerospace Workers Welfare Plan ("Plan") that the Trustees of the Plan adopted effective July 1, 2022. Please keep this notice with your copy of the Summary Plan Description ("SPD") for future reference.

This summary only provides information regarding the changes that have been made to the Plan and does not provide all of the information that may be relevant to a particular provision. For more information concerning the provisions addressed by this summary, you should consult your SPD booklet and previous summaries of material modification.

1. The second sentence of Section 1B is replaced with the following:

   You can find a directory of Network Providers on the website of the Managed Care Organization shown on your identification card and in Section 12H. The Network Provider Directory will be updated at least every ninety days. If you receive inaccurate information from the Directory (or in response to an inquiry to the Managed Care Organization or the Fund Office) indicating that a Provider is a Network Provider, services and supplies provided by that Non-Network Provider will be covered as if the provider was a Network Provider.

2. A new paragraph is added before the second to last paragraph of Section 1B as follows:

   Continuity of Coverage. If you are a Continuing Care Patient and your provider's status changes from Network to Non-Network, the Plan will notify you in a timely manner of your right to elect continued transitional care from the provider for a period of up to 90 days at Network cost-sharing levels.

3. The seventh paragraph of Section 1B is replaced with the following:

   Please note that benefits for Emergency Services provided at a Network facility by Non-Network Providers will be paid at the Network rate to the extent required by the No Surprises Act.

   With regard to non-Emergency Services or supplies that are otherwise covered by the Plan, if such services or supplies are provided by or performed by a Non-Network Provider at a Network facility, the services or supplies are covered by the Plan:

   - With a cost-sharing requirement that is not greater than the cost-sharing requirement that would apply if the services or supplies had been furnished by a Network Provider;

- By calculating the cost-sharing requirement as if the total amount that would have been charged for the services or supplies by a Network Provider were equal to the Recognized Amount for the services and supplies; and
- By counting cost-sharing payments you make with respect to Non-Network non-Emergency Services or supplies toward your Network deductible and Network out-of-pocket maximum.

Notice and Consent Exception: Non-Emergency Services or supplies performed by a Non-Network Provider at a Network facility will be covered based on your Non-Network coverage if:

- At least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), you are given written notice by the provider, as required by federal law, stating (1) that the provider is a Non-Network Provider with respect to the Plan, (2) the estimated charges for your treatment and any advance limitations that the Plan may apply to your treatment, (3) the names of any Network Providers at the facility who are able to treat you, and (4) that you may elect to be referred to one of the Network Providers listed; and
- You give informed consent to continued treatment by the Non-Network Provider, acknowledging that you understand that such continued treatment may result in greater cost to you.

The notice and consent exception does not apply to Ancillary Services and services or supplies furnished as a result of unforeseen, urgent medical needs that may arise at the time a service or supply is furnished, regardless of whether the Non-Network Provider satisfied the notice and consent criteria.

4. The third sentence of Section 1C is revised to read as follows:

   The Plan will pay 85% of covered charges of Network Providers and 55% of covered charges of providers who are not in the Network, other than as required by the No Surprises Act. See Section1B for an explanation of when the No Surprises Act requires payment of Non-Network charges at the Network rate.

5. The last sentence of the definition of **Allowable Charge** in Section 2B is revised to read as follows:

   Other than as required by the No Surprises Act, the Plan will not pay any allowable charge for Non-Network services or supplies that is determined by any provider, facility, or organization other than the Board of Trustees.

6. The definition of **Emergency** in Section 2B is replaced with the following:

   Emergency Medical Condition: A medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of

sufficient severity (including severe pain) so that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate health attention to result in serious jeopardy to the health of the individual (or for a pregnant individual, the health of the unborn child), serious impairment to bodily functions or serious dysfunction of any bodily organ or part. The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as an Emergency Medical Condition.

7. Section 2B is further revised by the addition of the following definitions:

Ancillary Services – Ancillary services include:

1. Services and supplies related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-Physician practitioner;
2. Services and supplies provided by assistant surgeons, hospitalists and intensivists;
3. Diagnostic services, including radiology and laboratory services; and
4. Services and supplies provided by a Non-Network Provider if there is no Network Provider who can furnish such item or service at such facility.

Continuing Care Patient – An individual who, with respect to a provider or facility is:

1. Undergoing a course of treatment for a serious and complex condition from the provider or facility;
2. Undergoing a course of institutional or inpatient care from the provider or facility;
3. Scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such surgery;
4. Pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
5. Determined to be terminally ill (as determined under Section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

Emergency Services: With respect to an Emergency Medical Condition:

1. An appropriate medical screening examination that is within the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including Ancillary Services routinely available in the Emergency Department to evaluate the Emergency Medical Condition, along with additional medical examination and treatment to the extent they are within the capabilities of the staff and facilities available to the Hospital or Freestanding Emergency Department to stabilize the patient;
2. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such

further medical examination and treatment as required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished); and

3. With respect to Non-Network Providers and facilities, post-stabilization services until the patient is determined by the provider or facility to be able to travel using nonmedical transportation to nonemergency medical transportation. At such time, the patient may give informed consent to continued treatment by the Non-Network Provider which treatment shall not be considered Emergency Services. Such consent must acknowledge that the patient understands that continued treatment by the Non-Network Provider may result in greater cost to the patient and may only be given after the patient is provided with a written notice, as required by federal law, stating (1) that the provider is a Non-Network Provider with respect to the Plan, (2) the estimated charges for treatment and any advance limitations that the Plan may apply to treatment, (3) the names of any Network Providers at the facility who are able to treat the patient, and (4) that the patient may elect to be referred to one of the Network Providers listed.

Independent Freestanding Emergency Department – A public or private facility, licensed and operated according to the law, which is geographically separate and distinct from a Hospital under applicable state law and provides Emergency Services.

Qualifying Payment Amount – The amount calculated using the methodology described in 29 CFR 2590.716-6(c) which is generally the contracted rates of the Plan for the service or supply in the geographic region, with certain exceptions.

Recognized Amount – For services or supplies furnished by a Non-Network Provider:

a. An amount determined by an applicable All-Payer Model Agreement;
b. If there is not applicable All-Payer Model Agreement, an amount determined by a specified state law; or
c. If there is no applicable All-Payer Model Agreement or specified state law, the lesser of the amount billed by the Provider or facility or the Qualifying Payment Amount.

For air ambulance services (if covered by the Plan), the lesser of the amount billed by the Provider or facility or the Qualifying Payment Amount.

8. A new sentence is added to the end of Section 8A4 as follows:

Note that in certain situations, which are described below in Section 8B, Non-Network services and supplies will be covered at the Network level in accordance with the No Surprises Act.

9. The second sentence of Section 8B is replaced with the following:

   You can find a directory of Network Providers on the website of the Managed Care Organization shown on your identification card and in Section 12H. The Network Provider Directory will be updated at least every ninety days. If you receive inaccurate information from the Directory (or in response to an inquiry to the Managed Care Organization or the Fund Office) indicating that a Provider is a Network Provider, services and supplies provided by that Non-Network Provider will be covered as if the provider was a Network Provider.

10. A new paragraph is added before the last paragraph of Section 8B as follows:

    Continuity of Coverage. If you are a Continuing Care Patient and your provider's status changes from Network to Non-Network, the Plan will notify you in a timely manner of your right to elect continued transitional care from the provider for a period of up to 90 days at Network cost-sharing levels.

11. The last paragraph of Section 8B is replaced with the following:

    Please note that benefits for Emergency Services provided at a Network facility by Non-Network Providers will be paid at the Network rate to the extent required by the No Surprises Act.

    With regard to non-Emergency Services or supplies that are otherwise covered by the Plan, if such services or supplies are provided by or performed by a Non-Network Provider at a Network facility, the services or supplies are covered by the Plan:

    - With a cost-sharing requirement that is not greater than the cost-sharing requirement that would apply if the services or supplies had been furnished by a Network Provider;
    - By calculating the cost-sharing requirement as if the total amount that would have been charged for the services or supplies by a Network Provider were equal to the Recognized Amount for the services and supplies; and
    - By counting cost-sharing payments you make with respect to Non-Network non-Emergency Services or supplies toward your Network deductible and Network out-of-pocket maximum.

    Notice and Consent Exception: Non-Emergency Services or supplies performed by a Non-Network Provider at a Network facility will be covered based on your Non-Network coverage if:

    - At least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), you are given written notice by the provider, as required by federal law, stating (1) that

the provider is a Non-Network Provider with respect to the Plan, (2) the estimated charges for your treatment and any advance limitations that the Plan may apply to your treatment, (3) the names of any Network Providers at the facility who are able to treat you, and (4) that you may elect to be referred to one of the Network Providers listed; and

- You give informed consent to continued treatment by the Non-Network Provider, acknowledging that you understand that such continued treatment may result in greater cost to you.

The notice and consent exception does not apply to Ancillary Services and services or supplies furnished as a result of unforeseen, urgent medical needs that may arise at the time an service or supply is furnished, regardless of whether the Non-Network Provider satisfied the notice and consent criteria.

12. The last sentence of the second paragraph of Section 8D2 is revised to read as follows:

    See Section 8B for description of the two levels of providers and for an explanation of when the No Surprises Act requires payment of Non-Network charges at the Network rate.

13. The following sentence is added to the end of 8D2:

    Note: the Plan's Out-of-Pocket Maximum amounts for Network and Non-Network Providers are separate and will not be combined, other than as required by the No Surprises Act, which counts payments made for Non-Network Emergency Services and Non-Emergency Services provided by a Non-Network Provider at a Network facility against your Network Out-of-Pocket Maximum.

14. The first sentence of Section 11C3a **Deadline for External Review** is replaced with the following:

    If you receive notice of an adverse benefit determination or final adverse internal appeal determination involving medical judgment, a rescission of coverage, or the Plan's compliance with the surprise billing and cost-sharing protections of the No Surprises Act with respect to Emergency Services, Non-Emergency Services provided by a Non-Network Provider at a Network facility, and/or air ambulance services (if covered by the Plan), you may file a request for an external review. The request for external review must be filed within four months after the date the claimant receives notice of the adverse benefit determination or final adverse internal appeal determination.

Please contact the Plan Office at (314) 739-6442 if you have any questions.

SUMMARY OF MATERIAL MODIFICATION TO THE
DISTRICT NO. 9, INTERNATIONAL ASSOCIATION OF MACHINISTS AND AEROSPACE WORKERS WELFARE PLAN

The following is a summary of changes to the C3GW Plan of the District No. 9, International Association of Machinists and Aerospace Workers Welfare Plan ("Plan") that the Trustees of the Plan adopted effective July 1, 2021. Please keep this notice with your copy of the Summary Plan Description ("SPD") for future reference.

This summary only provides information regarding the changes that have been made to the Plan and does not provide all of the information that may be relevant to a particular provision. For more information concerning the provisions addressed by this summary, you should consult your SPD booklet and previous summaries of material modification.

The first sentence in the first **Note** in Section 8.G.7c is revised to read as follows:

The maximum payment per visit shall be no more than the contracted rate between the medical network and the Licensed Practical Nurse or Registered Nurse providing the medical service.

Please contact the Plan Office at (314) 739-6442 if you have any questions.

SUMMARY OF MATERIAL MODIFICATION TO THE
DISTRICT NO. 9, INTERNATIONAL ASSOCIATION OF MACHINISTS AND AEROSPACE WORKERS WELFARE PLAN

The following is a summary of changes to the C3GW Plan of the District No. 9, International Association of Machinists and Aerospace Workers Welfare Plan ("Plan") that the Trustees of the Plan adopted effective November 1, 2021. Please keep this notice with your copy of the Summary Plan Description ("SPD") for future reference.

This summary only provides information regarding the changes that have been made to the Plan and does not provide all of the information that may be relevant to a particular provision. For more information concerning the provisions addressed by this summary, you should consult your SPD booklet and previous summaries of material modification.

The last row of the chart in Section 8.G.5.c is revised to read as follows:

Benefit Limit	Per procedure limit starts 5 days prior to the transplant and ends on the date of discharge for the transplant hospitalization. The benefit limit applies to Phase 3 and Phase 4 transplant charges, including the transplant procedure and post-transplant care. Pharmacy costs are not included in the transplant limit.	Not Covered

Please contact the Plan Office at (314) 739-6442 if you have any questions.

SUMMARY OF MATERIAL MODIFICATION TO THE
DISTRICT NO. 9, INTERNATIONAL ASSOCIATION OF MACHINISTS AND AEROSPACE WORKERS WELFARE PLAN

The following is a summary of changes to the C-3, C-3-D, C-3-G, C-3-T, C-3GW and D-9A Plans of the District No. 9, International Association of Machinists and Aerospace Workers Welfare Plan ("Plan") which were recently adopted by the Trustees of the Plan. Please keep this notice with your copy of the Summary Plan Description ("SPD") for future reference.

This summary only provides information regarding the changes that have been made to the Plan and does not provide all of the information that may be relevant to a particular provision. For more information concerning the provisions addressed by this summary, you should consult your SPD booklet and previous summaries of material modification.

1. Effective May 12, 2023, the last sentence of Section 8.G.1.a(4) of the SPD is deleted without replacement.

2. Effective May 12, 2023, Section 8.G.1.a(10) of the SPD is deleted without replacement.

3. Effective September 1, 2023, the second sentence of Section 8.G.3 of the SPD is revised to read as follows:

   The usual deductible, copays and co-insurance apply if preventive services are provided by a Non-Network Provider.

4. Effective September 1, 2023, Section 8.G.17 of the SPD is deleted without replacement:

Please contact the Plan Office at (314) 739-6442 if you have any questions.