AMENDMENT TO THE
SOUTHERN ILLINOIS LABORERS' & EMPLOYERS
HEALTH & WELFARE FUND SUMMARY PLAN DESCRIPTION

SUMMARY PLAN DESCRIPTION A – AMENDMENT #7
SUMMARY PLAN DESCRIPTION C – AMENDMENT #8

WHEREAS, the Board of Trustees of the Southern Illinois Laborers' & Employers' Health & Welfare Fund may amend the Summary Plan Description ("SPD") pursuant to Article 13 of the Restated Agreement and Declaration of Trust; and

WHEREAS, the Board of Trustees has determined that the following revisions are necessary to clarify and amend provisions of the SPD; and

NOW THEREFORE, effective as of the below referenced dates, the following language revisions and additions are hereby approved and incorporated into the applicable sections of the Plan A and Plan C SPD's:

Article 1 of the SPD for Plan A and Plan C entitled "Schedule of Benefits" is hereby amended as follows effective February 27, 2024 to include the following new provision:

Genetic Testing and Genetic Counseling Treatment (See Section 6)	Lifetime Benefit Maximum of $10,000 per Participant and Eligible Dependent

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Article 2, Section 2.08 of the SPD for Plan A and Plan C entitled "Maternity Benefits", is hereby amended as follows effective February 27, 2024:

Section 2.08 Maternity Benefits

Employee & Eligible Dependent Spouse Only

Maternity Benefit coverage of at least 48 hours of inpatient care after normal childbirth and 96 hours after a Caesarean section delivery. Shorter stays are permissible, if the attending physician consents to the shorter stay and after consultation with the mother and provided notification is given to both the Fund Office and Blue Cross Blue Shield of Illinois. In which case the Plan will allow two post-discharge visits; at least one of the visits must be provided at home.

Please note that Maternity Benefits for **Eligible Non-Spouse Female Dependents** are provided up to childbirth only.

Developmental Genetic Testing

The Plan will cover Reasonable any Customary expenses for chromosome microarray genetic testing of toddlers (defined as Eligible Dependent children ages 0-3), including post-testing temporary rehabilitation charges, subject to a determination of Medical Necessity by the Utilization Review Organization. Any ongoing or lifetime custodial or maintenance rehabilitation charges associated with a toddler's developmental disability, whether identified through the

chromosome microarray genetic testing or otherwise, will not be a Covered Expense under the Plan.

Maternity Limitations

1. The female Employee, Eligible Spouse or Dependent must be eligible for benefits at the time of delivery;
2. One amniocentesis will be allowed per pregnancy for the following reasons:
   A. Mother's blood type is Rh negative;
   B. In late pregnancy to determine maturity of lungs of fetus; or
   C. If the baby is post mature, to determine if needs of fetus are being adequately met in utero or if Caesarean section is necessary;
3. Benefits will be payable for one ultrasound during a normal pregnancy, with a second ultrasound also covered if determined as Medically Necessary; and
4. Benefits will be payable for Hospital room and board expenses only for a newborn child during the period that the mother is confined as a result of giving birth to the child. (See Article 3 for eligibility and enrollment information)

Benefits **will not** be payable for:

1. An elective abortion, but benefits will be payable for any complication which is the result of an elective abortion. Elective abortion means any abortion procedure other than one where the mother's life would be endangered if the fetus were carried to term, or abortion procedures offered by a provider to a patient subsequent to a finding of fetal acrania, exencephaly or anencephaly;
2. Any expense or charge for the promotion of fertility, including (but not limited to) fertility test, hormone therapy, artificial insemination, in vitro fertilization and embryo transfer; and
3. Genetic counseling <u>except as set forth in the Covered Charges section of this Summary Plan Description.</u> ~~(including genetic amniocentesis and chronic villus sampling)~~.

Effective May 15, 2024, Article 2, Subsection 2.12 of the SPD for Plan A and Plan C, entitled "Prescription Drug Card Program" is hereby amended as follows:

NON-COVERED PRESCRIPTION ITEMS:
Items lawfully obtained without a prescription
Allergy serums
Injectables – See Prior Authorization
Federal legend vitamins
Ostomy Supplies & Products
Fertility drugs
Rogaine
Diet Medications
Devices and applications – unless otherwise stated as covered
Growth hormone drugs<u>, except for the following treatments</u> (see Prior Authorization<u>):</u>
A. Medically Necessary gender affirmation treatment<u>; and/or</u>
B. <u>Medically Necessary treatment of a minor Eligible Dependent under the age of 18 to both promote development and to treat an existing medical condition or Illness.</u>
Viagra or any sexual dysfunction drugs
Prescriptions covered without charge under the Federal, State or local programs, to include Worker's Compensation

Any charge for administration of a drug or insulin
Investigational or experimental drugs
Unauthorized refills
Immunization agents, biological sera, blood plasma
Medication for an eligible member/Dependent confined to a nursing home, sanitarium, extended care facility, Hospital or similar entity
Any charge above the usual and customary, advertised or posted price, whichever is less than scheduled amount.

Article 6 of the SPD for Plan A and Plan C, entitled "Covered Charges", is hereby amended to include the following new paragraphs effective as of the below noted dates:

24. Medically Necessary services for growth hormone treatment of a minor eligible Dependent under the age of 18 if such services are required to both promote development and to treat an existing medical condition or Illness. *(effective May 15, 2024)*

25. Medically Necessary genetic testing and genetic counseling services, as set forth in the Schedule of Benefits, for you and your Eligible Dependent subject to the following requirements and conditions:
    A. The services must be ordered by the Participant or Eligible Dependent's treating medical professional;
    B. The services must be required to treat an existing or previously diagnosed medical condition or Illness, or the covered individual displays clinical features/symptoms, or is at direct risk (family history of 1st or 2nd degree relative) of developing the genetically linked heritable disease/condition in question (pre-symptomatic);
    C. The results of the test will directly impact the clinical decision-making, outcome or treatment being delivered to the covered individual; and
    D. The services are not Experimental and/or Investigative or considered not Medically Necessary. *(effective February 27, 2024)*

    Medically Necessary genetic testing and counseling services which meet the above defined criteria and are received during the course of pregnancy will be applied towards the Eligible Dependent's Lifetime Benefit Maximum as defined in the Schedule of Benefits section of this Summary Plan Description.

The following provision located in Article 8 "Definitions" of the SPD for Plan A and Plan C is hereby amended as follows effective February 27, 2024:

Section 8.38 Lifetime

A word that appears in this Plan in reference to benefit maximums and limitations. Lifetime or Lifetime Benefit Maximum ~~is understood to~~ means any period of time a Covered Person is eligible for benefits ~~while is covered~~ under this Plan. ~~Under no circumstances does lifetime mean during the lifetime of a Covered Person.~~

IN WITNESS HEREOF, this Amendment has been approved and signed by the Board of Trustees on this 23rd day of October, 2024, to be effective as of the aforementioned date(s).

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Chairman, Southern Illinois Laborers' and Employers Health & Welfare Fund

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Secretary, Southern Illinois Laborers' and Employers Health & Welfare Fund