Summary of Material Modification No. 9

to the

IBEW Local 347 Electrical Workers Health and Welfare Fund
Combination Plan Document and Summary Plan Description

The purpose of this Summary of Material Modification ("SMM") is to provide you a summary of changes and clarifications that were made to the IBEW Local 347 Electrical Workers Health and Welfare Combination Plan Document and Summary Plan Description ("SPD"). We suggest you keep this SMM with your SPD. This SMM is also available at the website www.ibew347benefits.com. If you would like a copy of the full text of the new SPD provisions or have any questions, please contact the Fund Office.

The following terms have a specific meaning when they are used in this SMM:

- The term "**ancillary benefit**" means one of the following: (1) items and services that relate to emergency medicine, anesthesiology, pathology, radiology, and neonatology; (2) diagnostic services, including radiology and laboratory services; (3) items and services provided by assistant surgeons, hospitalists, and intensivists; (4) items and services provided by non-PPO providers when there is no PPO Provider that can furnish it at the PPO Provider's Hospital or Facility; and (5) items and services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished.

- The term "**non-ancillary benefit**" means a benefit that is not an ancillary benefit.

- The term "**No Surprises Act**" means the No Surprises Act that was signed into law as part of the Consolidated Appropriations Act of 2021.

- The term "**balance billed**" refers to a Covered Person being billed by a non-PPO provider for the difference between the non-PPO provider's charge for items and services and the amount paid by the Plan to the non-PPO provider for the items and services. For example, if you receive a $100 service from a non-PPO provider, the Plan pays the non-PPO provider $70 for the service, and the non-PPO provider bills you for the remaining $30, you have been "balance billed" for $30.

- The term "**continuing care patient**" means a Covered Person who, with respect to a provider, is: (1) undergoing a course of treatment for a serious and complex condition from the provider; (2) undergoing a course of institutional or inpatient care from the provider; (3) scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from the provider with respect to such surgery; (4) pregnant and undergoing a course of treatment for the pregnancy from the provider; or (5) determined to be terminally ill and is receiving treatment for such illness from the provider.

1. New Rule Regarding Coverage of Items and Services Furnished by Non-PPO Providers at PPO Providers' Hospitals and Facilities:

Prior to January 1, 2022, the Plan provided that it would generally pay 60% of Covered Charges for items and services you received from a non-PPO provider at a PPO Hospital or Facility after you met your Deductible. The Plan further provided that it would generally pay 80% of Covered Charges for items and services you received from a non-PPO provider at a PPO Hospital or Facility after you met your Annual Out-of-Pocket Maximum. These rules were reflected in Article II of your SPD.

Effective January 1, 2022, the Plan was amended to provide that if you receive ancillary benefits from a non-PPO provider at a PPO Hospital or Facility, the Plan will apply the same cost-sharing that it applies to PPO Providers. This means that if you receive ancillary benefits from a non-PPO provider at a PPO Hospital or Facility, the Plan will generally pay 80% of Covered Charges for the items and services after you have met your Deductible. This also means that if you receive ancillary benefits from a non-PPO provider at a PPO Hospital or Facility, the Plan will pay 100% of Covered Charges for the items and services after you have met your Annual Out-of-Pocket Maximum.

Effective January 1, 2022, the Plan was also amended to provide that if you receive non-ancillary benefits from a non-PPO provider at a PPO Hospital or Facility, the Plan will apply the same cost-sharing that it applies to PPO Providers unless the non-PPO provider provides you with notice of your rights under the No Surprises Act and you consent to be balance billed. This means that if you receive non-ancillary benefits from a non-PPO provider at a PPO Hospital or Facility, the Plan will generally pay 80% of Covered Charges after you have met your Deductible unless the non-PPO provider provides you with notice of your rights under the No Surprises Act and you consent to be balance billed. This also means that if you receive non-ancillary benefits from a non-PPO provider at a PPO Hospital or Facility, the Plan will pay 100% of Covered Charges for the items and services after you have met your Annual Out-of-Pocket Maximum unless the non-PPO provider provides you with notice of your rights under the No Surprises Act and you consent to be balance billed.

Based on these changes, Section 2.04 of your SPD was amended to read as follows:

> ***Section 2.04 – Services Rendered by a non-PPO provider at a PPO Hospital or Facility***
> When you receive items and services at a Hospital or Facility that is in the UnitedHealthcare (UHC Choice Plus) network (i.e., the Hospital or Facility is a PPO Provider), certain providers there may be non-PPO providers. Unless you consent in writing to be billed at the non-PPO provider rate, the Plan will pay for items and services provided by the non-PPO providers at a UnitedHealthcare (UHC Choice Plus) network Hospital or Facility at the same rate that the Plan would pay had you received the items and services from a PPO Provider. Even if you consent in writing to be billed at the non-PPO provider rate, the Plan will pay for certain "ancillary benefits" at the same rate that the Plan would pay had you received the items or services from a PPO Provider.
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> If you have met your Annual Out-of-Pocket Maximum and you receive an item or service from a non-PPO provider at a Hospital or Facility that is in the UnitedHealthcare (UHC Choice Plus) network (i.e., the Hospital or Facility is a PPO Provider), the Plan will pay 100% of the Covered Charges for the item or service unless you consent in writing to be billed at the non-PPO provider rate. Even if you consent in writing to be billed at the non-PPO provider rate, the Plan will pay 100% of the Covered Charges for ancillary benefits.
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> An "ancillary benefit" constitutes one of the following: (1) items and services that relate to emergency medicine, anesthesiology, pathology, radiology, and neonatology; (2) diagnostic services, including radiology and laboratory services; (3) items and services provided by assistant surgeons, hospitalists, and intensivists; (4) items and services provided by non-PPO providers when there is no PPO Provider that can furnish it at the UnitedHealthcare (UHC Choice Plus) network Hospital or Facility; and (5) items and services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished.

2. <u>New Rule Regarding Coverage for Air Ambulance Services Provided by a Non-PPO Provider</u>:

Prior to January 1, 2022, the Plan provided that it would pay 80% of your Covered Charges for Ambulance Services after you met your Deductible, regardless of whether the services were provided by a PPO Provider or a non-PPO provider. The Plan also provided that after you met your Annual Out-of-Pocket Maximum, the Plan would pay 100% of your Covered Charges for Ambulance Services provided by a PPO Provider and 80%

of Covered Charges for Ambulance Services provided by a non-PPO provider. These rules were reflected in Section 2.06 of your SPD.

Effective January 1, 2022, the Plan was amended to provide that if you are transported in a non-PPO provider's air ambulance, the Plan will apply the same cost-sharing that would apply had you been transported in a PPO Provider's air ambulance. This means that if you are transported in a non-PPO provider's air ambulance, the Plan will pay 80% of your Covered Charges after you have met your Deductible. This also means that if you are transported in a non-PPO provider's air ambulance, the Plan will pay 100% of your Covered Charges after you have met your Annual Out-of-Pocket Maximum.

Based on this change, Section 2.06 of your SPD was amended to read as follows:

> ***Section 2.06 – Ambulance Services***
> The Plan covers licensed ambulance services for ground transportation to or from a Hospital. After a Covered Person has met his Deductible, the Plan will pay 80% of Covered Charges for ground ambulance services regardless of whether the services are provided by a PPO Provider or a non-PPO provider. Once a Covered Person has met his Annual Out-of-Pocket Maximum, the Plan will pay 100% of Covered Charges for ground ambulance services provided by a PPO Provider and 80% of Covered Charges for ground ambulance services provided by a non-PPO provider.
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> The Plan will also cover a licensed air ambulance if the location and nature of the Sickness or Injury make air transportation cost-effective or necessary to avoid the possibility of serious complications or loss of life. After a Covered Person has met his Deductible, the Plan will pay 80% of Covered Charges for air ambulance services regardless of whether the services are provided by a PPO Provider or a non-PPO provider. Once a Covered Person has met his Annual Out-of-Pocket Maximum, the Plan will pay 100% of Covered Charges for air ambulance services regardless of whether the services are provided by a PPO Provider or a non-PPO provider.

3. **<u>Increase in Emergency Room Copay and New Rule Regarding Coverage for Items and Services Furnished at a Non-PPO Hospital or Facility for Medical Emergencies</u>**:

Prior to January 1, 2022, the Plan provided that it would generally pay 80% of Covered Charges for Hospital – Emergency Room Services provided by a non-PPO provider after you met your deductible and paid a $70 Copay. The Plan also provided that when you received treatment for a Medical Emergency at a non-PPO Hospital emergency room, either because of circumstances beyond your control or because the time necessary to obtain treatment from a PPO Provider could endanger your life, the Plan would pay 100% of Covered Charges for the Hospital Emergency Room Services after you met your Deductible and paid a $70 Copay. These rules were reflected in Section 2.17 of your SPD and SMM No. 7.

Effective January 1, 2022, the Copay for Emergency Room Services is $80. Also effective January 1, 2022, the Plan was amended to provide that if you receive items or services for a Medical Emergency at a non-PPO Hospital or Facility, the Plan will apply the same cost-sharing that would apply had you received the items or services at a PPO Hospital or Facility. This means that if you receive items or services for a Medical Emergency at a non-PPO Hospital or Facility, the Plan will pay 100% of Covered Charges for Hospital – Emergency Room Services after you have met your Deductible and paid an $80 Copay, regardless of whether or not the items or services were provided at the non-PPO Hospital emergency room due to circumstances beyond your control or because the time necessary to obtain treatment from a PPO Provider would have endangered your life.

Based on these changes, the Summary of Benefits on page 9 of your SPD and the Comprehensive Medical Benefits summary on page 48 of your SPD have been amended at "Hospital – Emergency Room Services" to read as follows:

SERVICE	PPO PROVIDER	NON-PPO PROVIDER
HOSPITAL - EMERGENCY ROOM SERVICES	100% after $80 Copay* and Deductible	80% after $80 Copay* and Deductible**

* Hospital Emergency Room Copay is waived if admitted.

** After a Covered Person has met his Deductible and paid an $80 Copay, if applicable, the Plan will pay 100% of Covered Charges for Hospital – Emergency Room Services if the Covered Person receives treatment for a Medical Emergency at a non-PPO Hospital emergency room.

Further, Section 2.17 of your SPD was amended to read as follows:

Section 2.17 – Hospital – Emergency Room Services

The Plan covers use of a Hospital emergency room. The Plan also covers the treatment and services that a Covered Person receives when he is in a Hospital emergency room. The treatment and services covered under this Section include treatment for mental health and substance abuse. After a Covered Person has met his Deductible and paid an $80 Copay, the Plan will pay 100% of Covered Charges for Hospital - Emergency Room Services provided by a PPO Provider. After a Covered Person has met his Deductible and paid an $80 Copay, the Plan will pay 80% of Covered Charges for Hospital - Emergency Room Services provided by a non-PPO provider unless the Covered Person receives treatment for a Medical Emergency. If a Covered Person receives treatment for a Medical Emergency at a non-PPO Hospital emergency room, the Plan will pay 100% of Covered Charges for treatment provided by the non-PPO provider after the Covered Person has met his Deductible and paid an $80 Copay.

When a Covered Person receives treatment for a Medical Emergency at a non-PPO Hospital emergency room, the Covered Person has two options once he is medically stable:

- The Covered Person may transfer to a PPO Provider and the Plan will pay 80% of all future incurred Covered Charges; or

- The Covered Person may elect to stay at the non-PPO provider and the Plan will pay 60% of all future incurred Covered Charges.

If the Covered Person is admitted to the Hospital, the $80 Copay will be waived. Once a Covered Person is admitted to the Hospital, benefits will be paid in accordance with Section 2.18.

4. <u>Additional Specialty Drugs that Have Manufacturer Assistance Available</u>:

As explained in the table at the beginning of Article III of your SPD and the table at the beginning of SMM No. 7, Specialty Drugs are generally subject to a Copay. Effective January 1, 2020, the Plan started utilizing Sav-Rx's High Impact Advocacy ("HIA") program. Based on the Plan's utilization of Sav-Rx's HIA program, the Prescription Drug Benefit Copays listed in the tables at the beginning of Article III of your SPD and SMM No. 7 do not apply to Specialty Drugs that have manufacturer assistance available. Instead, the copayments in the following chart apply to Specialty Drugs that have manufacturer assistance available:

If the Specialty Drug was prescribed to treat…	Your copayment would equal…

Multiple sclerosis, an inflammatory condition, or Cancer	20% of the cost of the drug*
Hepatitis C	25% of the cost of the drug*
Cystic Fibrosis	30% of the cost of the drug*
* If the amount of the manufacturer assistance available for the Specialty Drug is less than the amount of the copayment, then your copayment will equal the amount of the manufacturer assistance available for the Specialty Drug. This means that the manufacturer assistance will cover your copayment and you will not pay anything for the Specialty Drug.	

These rules were reflected in SMM No. 8.

Effective July 1, 2020, several additional classes of Specialty Drugs were added to the HIA program. Based on the Plan's utilization of Sav-Rx's HIA program, effective July 1, 2020, the following copayments apply to Specialty Drugs that have manufacturer assistance available:

If the Specialty Drug is …	**Your copayment will equal…**
Ozempic or Rybelsus	15% of the cost of the drug*
A brand HIV agent or prescribed to treat multiple sclerosis, an inflammatory condition, or Cancer	20% of the cost of the drug*
Prescribed to treat hepatitis C	25% of the cost of the drug*
Aimovig, Ajovy, Emgality, Nurtec, Vyepti, Ubrelvy, Reyvow, or prescribed to treat Cystic Fibrosis	30% of the cost of the drug*
Repatha	35% of the cost of the drug*
A drug that has manufacturer assistance available but is not listed above	40% of the cost of the drug*
* If the amount of the manufacturer assistance available for the Specialty Drug is less than the amount of the copayment, then your copayment will equal the amount of the manufacturer assistance available for the Specialty Drug. This means that the manufacturer assistance will cover your copayment and you will not pay anything for the Specialty Drug.	

This means that if you are prescribed a Specialty Drug that has manufacturer assistance available, the Plan's prescription drug benefit Copays that are listed in the table at the beginning of Article III of your SPD and the table at the beginning of SMM No. 7 do not apply to the Specialty Drug.

Other aspects of the HIA program described in SMM No. 8 have not changed. This means that the way the HIA program works, both before and after July 1, 2020, is that when you send Sav-Rx an order to fill your prescription for a Specialty Drug, Sav-Rx will apply for the manufacturer assistance that is available for that drug and then use that assistance to pay your copayment. The result is that you will pay $0.00 for the Specialty Drug (i.e., you will not have to pay anything for the Specialty Drug because the amount of the assistance will equal the amount of the copayment).

For example, if you have cancer and you are prescribed a Specialty Drug that is on Sav-Rx's HIA program list, you should order that drug from the Sav-Rx Mail Order Pharmacy. Once Sav-Rx receives the order, Sav-Rx will apply for manufacturer assistance. If the cost of the Specialty Drug is $5,000 and Sav-Rx receives manufacturer assistance in the amount of $1,000, then your copayment for the Specialty Drug is $1,000. Sav-Rx will apply the $1,000 from the drug manufacturer towards your copayment, which means you will pay $0.00 for the Specialty Drug.

5. **Changes to Specialty Drug Supply Limits:**

Prior to May 1, 2022, all Specialty Drugs were limited to a 30-day supply. This rule was explained in Section 3.04 of your SPD and SMM No. 7.

Effective May 1, 2022, the supply limit for certain Specialty Drugs increased to 90 days. The Specialty Drugs that are subject to the 90-day limit and the copayments for these drugs are as follows:

If your prescription is for …	**Your copayment for a 30-day supply of the drug will equal …**	**Your copayment for a 90-day supply of the drug will equal …**
Generic HIV Agents, Generic Transplant Agents	$50	$100
Ozempic*, Rybelsus*	15% of the cost of the drug	15% of the cost of the drug
Brand HIV Agents*	20% of the cost of the drug	20% of the cost of the drug
Aimovig*, Ajovy*, Emgality*, Nurtec*, Vyepti*, Ubrelvy*, Reyvow*	30% of the cost of the drug	30% of the cost of the drug
Repatha*	35% of the cost of the drug	35% of the cost of the drug
* These Specialty Drugs have manufacturer assistance available. For more information about the Plan's coverage for Specialty Drugs that have manufacturer assistance available, refer to the previous section of this SMM No. 9.		

This list is subject to change. For a current list of Specialty Drugs for which 90-day supplies are available, contact Sav-Rx at (800) 228-3108.

The 30-day Specialty Drug limit will continue to apply to all Specialty Drugs that are not listed in the chart. Additionally, if your Physician prescribes you a new Specialty Drug that is listed in the chart, the Plan will only cover a 30-day supply of your initial prescription for the Specialty Drug unless a 90-day supply is deemed clinically

appropriate by Sav-Rx. The reason for this rule is that Specialty Drugs have unique characteristics, such as the need for frequent dosage adjustments, narrow therapeutic ranges, and the tendency to cause more severe side effects than traditional drugs. As such, Sav-Rx needs to ensure that you will likely continue to take the Specialty Drug for the foreseeable future before the Plan will cover a 90-day supply of the drug.

The rest of the Plan's rules regarding coverage for Specialty Drugs still apply to the Specialty Drugs in the chart above. For more information about the Plan's coverage of Specialty Drugs, refer to Article III of your SPD, SMM No. 3, SMM No. 5, SMM No. 7, SMM No. 8, and the previous section of this SMM No. 9, call Sav-Rx at (800) 228-3108, or visit Sav-Rx's website www.savrx.com.

6. **New Rule Regarding Benefit Exclusions and Limitations**:

Prior to January 1, 2022, benefits were not payable for any charge incurred or resulting from any of the scenarios listed in the Plan's benefit exclusions and limitations. This rule was reflected in Section 8.01 of your SPD.

Effective January 1, 2022, the Plan was amended to provide that charges incurred or resulting from the scenarios listed in the Plan's benefit exclusions and limitations will be payable, to the extent required by the No Surprises Act, if you incurred the charge due to a Medical Emergency. Based on this change, Section 8.01 of your SPD was amended to insert the following sentence at the end:

> The Benefits Exclusions and Limitations in this Section do not apply to Hospital – Emergency Room Services in Section 2.17 rendered for a Medical Emergency to the extent required by the No Surprises Act.

7. **New External Review for Adverse Benefit Determinations Related to Compliance with the No Surprises Act.**

Prior to January 1, 2022, if a claim for benefits was denied, in whole or in part, or if the amount approved or paid varied in any other way from the total amount claimed, you could appeal the determination by filing a written request for review to the Board of Trustees. You could also request a hearing where you could appear in person to present your appeal to the Trustees. If you followed the Plan's internal claims and appeals procedures and you still disagreed with the determination, you could file suit in a state or Federal court. These rules were reflected in Sections 9.06 and 9.08 of your SPD.

Effective January 1, 2022, the Plan was amended to provide that you may seek external review of your claim if the adverse benefit determination relates to compliance with the No Surprises Act. If you followed the Plan's internal claims and appeals procedures, you still disagree with the determination, and your adverse benefit determination relates to compliance with the surprise billing and cost-sharing protections of the No Surprises Act, you may request that an Independent Review Organization ("IRO") conduct an external review of your claim. Based on this change, Article IX of your SPD was amended by inserting the following Section 9.13:

> ***Section 9.13 – External Review with Independent Review Organization ("IRO") for Adverse Benefit Determinations Related to Compliance with the Surprise Billing and Cost-Sharing Protections under the No Surprises Act***
>
> If you followed the Plan's internal claims and appeals procedures described in this Article IX, you still disagree with the determination, and your adverse benefit determination relates to compliance with the surprise billing and cost-sharing protections under Title I of the Consolidated Appropriations Act of 2021 ("No Surprises Act"), you may request that an IRO conduct an external review of your claim in accordance with this Section 9.13. Your claim will only qualify for external review if it relates to compliance with the surprise billing and cost-sharing protections under the No Surprises Act, as

described in Section 9.13(a). External review is not available for other types of adverse benefit determinations.

(a) Surprise billing and cost-sharing protections under the No Surprises Act

To be eligible for external review, your adverse benefit determination must relate to compliance with the surprise billing and cost-sharing protections under the No Surprises Act. This means that your claim must involve at least one of the following:

(1) Emergency Medical Services from Non-PPO Providers

Under the No Surprises Act, the Plan must cover emergency services, regardless of whether the services are provided by a PPO Provider or a non-PPO provider. To the extent emergency services are provided by a non-PPO provider, the Plan cannot impose any requirement or limitation that is more restrictive than the requirement and limitation that would apply had the emergency services been provided by a PPO Provider. Additionally, the Plan cannot impose cost-sharing requirements with respect to emergency services provided by a non-PPO provider that are greater than the cost-sharing requirements that would apply had the emergency services been provided by a PPO Provider.

(2) Non-Emergency Services from Non-PPO Providers at Hospitals and Facilities that are in the UnitedHealthcare (UHC Choice Plus) network ("PPO Provider Hospital or Facility")

Under the No Surprises Act, to the extent non-emergency services are provided by a non-PPO provider at a PPO Provider Hospital or Facility, the Plan cannot impose cost-sharing requirements with respect to the services that are greater than the cost-sharing requirements that would apply had the services been provided by a PPO Provider unless the Covered Person provides written consent. Even if the Covered Person provides written consent, the Plan cannot impose cost-sharing requirements with respect to the ancillary services described in Section 2.04.

(3) Air Ambulance Services from Non-PPO Providers

Under the No Surprises Act, if air ambulance services would be covered by a PPO Provider, the Plan cannot impose cost-sharing requirements with respect to air ambulance services from non-PPO providers that are greater than the cost-sharing requirements that would apply had the services been provided by a PPO Provider.

(b) External Review Process

(1) How to file requests for external review

You may file a request for external review of your claim by sending UnitedHealthcare a written request for an IRO to review your claim. This request should not be filed until after you receive notification of the benefit determination on appeal (i.e., after the date that you receive the notice described in Section 9.11). UnitedHealthcare must receive your request for external review within four months after the date that you receive notification of the benefit determination on appeal.

(2) Preliminary review of external review requests

UnitedHealthcare will render a determination on whether or not your request is eligible for external review. The time period for rendering this determination begins as soon as your request for external review is received by UnitedHealthcare in accordance with Section 9.13(b)(1). Your request will be eligible for external review if it meets all of the following criteria:

- You were covered by the Plan at the time the health care item or service was requested;
- Your claim relates to compliance with the surprise billing and cost-sharing protections under the No Surprises Act;
- You exhausted the Plan's internal claims and appeals procedures or your claim is deemed exhausted in accordance with Section 9.11; and
- You provided all the information and forms required to process your request for external review.

You will receive notice of UnitedHealthcare's determination within a reasonable period of time, but no later than six business days after the date that UnitedHealthcare receives your request for external review.

(3) Content of preliminary determination of requests for external review

If UnitedHealthcare determines that your request qualifies for external review, you will receive a written notice that contains sufficient information to fully apprise you that your request qualifies for external review.

If UnitedHealthcare determines that your request does not qualify for external review, you will receive a written notice of this determination. This notice will include the specific reason(s) that your request is not eligible for external review and the current contact information, including the phone number, for the Employee Benefits Security Administration ("EBSA").

If UnitedHealthcare needs additional information from you to determine whether or not your request is eligible for external review, UnitedHealthcare will notify you of the information necessary to complete your request. If this occurs, your request will only be eligible for external review if it meets at least one of the following criteria:

- UnitedHealthcare receives the additional information within four calendar months after the date that you receive notification of the benefit determination on appeal (i.e., four calendar months after the date that you receive the notice described in Section 9.11); or
- UnitedHealthcare receives the additional information within 48 hours after you receive the notice describing the information needed to determine whether or not your request is eligible for external review (i.e., 48 hours after you receive the notice described in this Section 9.13(b)(3)).

(4) IRO review of requests for external review

If your request is complete and eligible for external review, your request will be assigned to an IRO. Within five business days after the date of assignment of the IRO, UnitedHealthcare will provide the IRO with any information and materials considered in rendering a determination on your claim.

The IRO will timely notify you, in writing, of the acceptance of your request for external review. The IRO's initial notice will include directions on how you may submit additional information relating to your claim. You may submit such additional information during the ten business days following the date you received the initial notice from the IRO. The IRO will review all information and documents received within this time period. The IRO may, but is not required to, accept and consider any additional information that you

submit after the ten business days following the date you receive the initial notice from the IRO.

The IRO will conduct a full and fair review of your appeal without giving deference to the previous benefit determinations. However, the IRO will be bound by the terms of the Plan Document. You will receive notice of the IRO's determination no later than 45 calendar days after the date that the IRO receives your request for external review.

If you submitted additional information to the IRO, the IRO will forward the information to UnitedHealthcare within one business day after the date that the IRO receives this information. Upon receipt of this information, UnitedHealthcare may reconsider whether or not your claim is covered by the Plan. Reconsideration by UnitedHealthcare will not delay the external review. If UnitedHealthcare reconsiders your claim and, prior to the date that the IRO renders a determination, UnitedHealthcare determines that your claim is covered by the Plan, the external review will be terminated (i.e., if UnitedHealthcare determines that your claim is covered, it will no longer be necessary for the IRO to review your claim). If this occurs, UnitedHealthcare will provide you and the IRO with notice of its determination no later than one business day after the date that UnitedHealthcare renders a determination.

(5) Content of IRO determination

You will receive a written notice of the IRO's determination. This notice will include the following information:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);
- The date the IRO received the assignment to conduct external review and the date of the IRO's determination;
- References to the evidence and/or documentation considered by the IRO in reaching its determination, including the specific coverage provisions and evidence based standards;
- A discussion of the principal reason(s) for the IRO's determination, including its rationale and any evidence-based standards that were relied upon in making the determination;
- A statement that the diagnosis code, the treatment code, and their corresponding meanings will be provided to you as soon as practicable upon request;
- A statement that the reason for UnitedHealthcare's denial will be provided to you as soon as practicable upon request;
- A statement that the IRO's determination is binding except to the extent that other remedies may be available under state or federal law to either you or the Plan, or to the extent the Plan voluntarily makes payment on your claim;
- A statement that you have the right to bring civil action under Section 502(a) of ERISA; and
- A disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the PHSA to assist individuals with the internal claims and appeals and external review processes.

(6) Effect of IRO determination

If the IRO reverses UnitedHealthcare's determination, the Plan will immediately cover your claim.

If the IRO does not reverse UnitedHealthcare's determination, the Plan will not cover your claim.

The IRO's determination is binding upon the Plan, UnitedHealthcare, and you, except to the extent that you or the Plan may have other remedies available under applicable federal or state law. You may not file a subsequent request for external review involving the same adverse benefit determination for which you have already received an external review determination.

8. <u>New Definition of Medical Emergency</u>:

Prior to January 1, 2022, the Plan defined "Medical Emergency" to mean "any situation in which, due to an Injury or Sickness, a person required immediate medical care and delay could endanger the person's life, health, functioning or could cause extreme pain that cannot be controlled without such medical care." This definition was reflected in Section 15.28 of your SPD.

Effective January 1, 2022, the Plan was amended by replacing the definition of "Medical Emergency" with the following language:

Section 15.28 – Medical Emergency
"Medical Emergency" means any medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson could reasonably expect the absence of immediate medical attention to: (1) place the health of the Covered Person (or, with respect to a pregnant Covered Person, the health of the unborn child) in serious jeopardy; (2) result in serious impairment of bodily functions; or (3) result in serious dysfunction of any bodily organ or part.

9. <u>New Definition of PPO Provider</u>:

Prior to January 1, 2022, the Plan defined "Preferred Provider or PPO Provider" to mean "a Hospital, Facility, Physician, vision provider or other provider that has agreed to participate in the Plan's Preferred Provider Organization (PPO) network. The Plan currently utilizes UnitedHeathcare as its medical PPO Provider and VSP as its vision Preferred Provider." This definition was reflected in Section 15.40 of your SPD. This means that prior to January 1, 2022, upon your provider becoming a non-PPO provider, the Plan would have generally paid 60% of your Covered Charges after you met your Deductible and 80% of Covered Charges after you have met your Annual Out-of-Pocket Maximum.

Effective January 1, 2022, the Plan was amended by replacing the definition of "Preferred Provider or PPO Provider" with the following language:

Section 15.40 – Preferred Provider or PPO Provider
"Preferred Provider" or "PPO Provider" means a Hospital, Facility, Physician, Vision provider, or other provider that has agreed to participate in the Plan's Preferred Provider Organization ("PPO") network. The Plan currently utilizes UnitedHealthcare's PPO network for Comprehensive Medical Benefits and VSP's PPO network for Vision Benefits. With respect to continuing care patients, "Preferred Provider" or "PPO Provider" also means a former PPO Provider that was rendering items or services to a continuing care patient on the date the provider ceased to be a PPO Provider until the earlier of: (1) 90 days after the date the Covered Person is notified that the provider is no longer a PPO Provider; or (2) the date the Covered Person is no longer a continuing care patient.

For purposes of this definition, a Covered Person is a "continuing care patient" if, with respect to the provider, the Covered Person is: (1) undergoing a course of treatment for a serious and complex

condition from the provider; (2) undergoing a course of institutional or inpatient care from the provider; (3) scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from the provider with respect to such surgery; (4) pregnant and undergoing a course of treatment for the pregnancy from the provider; or (5) determined to be terminally ill and is receiving treatment for such illness from the provider.

This means that if you meet the definition of continuing care patient and you choose to continue treatment with a former PPO Provider, the Plan will generally pay 80% of your Covered Charges after you have met your deductible for up to 90 days after you are notified that the provider left the UnitedHealthcare network. After you have met your Annual Out-of-Pocket Maximum, the Plan will pay 100% of your Covered Charges for up to 90 days after you are notified that the provider left the UnitedHealthcare network.

10. <u>New Definition of Prevailing Charge</u>:

Prior to January 1, 2022, the Plan defined "Prevailing Charges" for non-PPO providers to mean "the usual and customary amount that most health care providers within a geographic cost area charge for treatment." This definition was reflected in Section 15.41 of your SPD.

Effective January 1, 2022, the Plan was amended by replacing the definition of "Prevailing Charges" with the following language:

Section 15.41 – Prevailing Charges
"Prevailing Charges" means:

- For treatment received from PPO Providers, the negotiated fee between the provider and UnitedHealthcare or VSP, as applicable;
- For either: (1) items or services furnished by a non-PPO provider for a Medical Emergency; or (2) items or services furnished by a non-PPO provider at a PPO Hospital or Facility (unless the Covered Person consented to not be balance billed and the items or services are not ancillary benefits, as that term is defined in Section 2.04):
    - The rate articulated in an All-Payer Model Agreement if the services are rendered in a state that has such an agreement;
    - The rate specified by state law; or
    - The Qualifying Payment Amount;
- For air ambulance services, the lesser of the billed amount or the Qualifying Payment Amount;
- For all other treatment received from non-PPO providers, the usual and customary amount that most health care providers within a geographic cost area charge for treatment;
- For drugs and medicines requiring a Physician's prescription and considered a covered treatment, Prevailing Charges will not exceed the negotiated amount for Participating Pharmacies. For nonparticipating pharmacies, the Prevailing Charges will not exceed the amount the Plan would have paid for the prescription if it was filled at a Participating Pharmacy; and
- For dental services, the amount which Delta Dental establishes as its maximum allowable fee for dental services contained in the "Current Dental Terminology" published by the American Dental Association. For dental services received outside of Iowa, the Prevailing Charge is based upon information from that state's Delta Dental Member Company.

For purposes of this definition, the "Qualifying Payment Amount" is the median of the contracted rates recognized by the Plan on January 31, 2019 for the same or similar item or service that is provided in a geographic region, increased for inflation.

Grandfathered Status

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventative health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at (844) 347-IBEW (4239). You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or: www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.