Summary of Material Modification No. 10

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 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.

1. Extension of the Special Rule for Retirees who Return to Covered Employment Between January 1, 2015 and September 30, 2023

Effective January 1, 2015, a special rule was added to the Plan for Retirees who returned to Covered Employment between January 1, 2015 and September 30, 2015. This special rule was subsequently extended. Based on this extension, effective January 1, 2023, the rule will apply to Retirees who return to Covered Employment between January 1, 2015 and September 30, 2023 and meet the criteria below.

As explained in greater detail in Section 1.12 of your SPD, if a Retiree returns to Covered Employment for 120 or more hours during a consecutive three-month period, the individual will no longer be considered a Retiree on the first day of the third month after (s)he has worked for 120 or more hours during a consecutive three-month period. Generally, when this occurs, the Retiree will not be permitted to receive coverage from the Plan as a Retiree for twelve consecutive months after the date that his or her Retiree eligibility and coverage were terminated. The individual may be permitted to receive coverage under the Plan as a Covered Employee during these twelve months if his or her eligibility and coverage as a Covered Employee are reinstated in accordance with Section 1.15(b) of your SPD.

The special rule provides that if a Retiree meets all the following requirements, (s)he will not be subject to the rule in the paragraph above which prohibits a Retiree from receiving coverage from the Plan as a Retiree for twelve consecutive months from the date that his or her Retiree eligibility and coverage were terminated:

- The Retiree must have returned to Covered Employment between January 1, 2015 and September 30, 2023;
- The Retiree's eligibility and coverage from the Plan must have been terminated in accordance with Section 1.13(b) between January 1, 2015 and December 31, 2023; and
- After the occurrence of the events in both of the bullet points above, the Retiree must have completely ceased working in Covered Employment between January 1, 2015 and December 31, 2023.

This means that pursuant to this special rule, a Retiree who meets all of the above requirements may receive coverage from the Plan as a Retiree on the first day of the month after (s)he has fulfilled all of the requirements of Section 1.06 or Section 1.07 of the Plan, as applicable.

These amendments alter the provisions of Section 1.12 of the SPD, entitled ***Retiree's Return to Work for an Employer.***

2. <u>Supplemental Annual Out-Of-Pocket Maximum - Comprehensive Medical Benefits</u>

The Plan currently provides for a single Annual Out-of-Pocket Maximum limit on the costs for Comprehensive Medical Benefits you are responsible for under the Plan. Under this limit, once you have met your Deductible and incurred $3,000 of Covered Charges for Comprehensive Medical Benefits in a calendar year, you have met your Annual Out-of-Pocket Maximum. This means that for the rest of that calendar year, the Plan will pay 100% of Covered Charges for most Comprehensive Medical Benefits provided by a PPO Provider and 80% of Covered Charges for most Comprehensive Medical Benefits provided by a non-PPO provider. However, if you utilize a benefit that requires a Copay, you still must pay the required Copay even after you have met your Annual Out-of-Pocket Maximum. There is currently no limit on the number of individual Copays you have to pay.

Based on this Annual Out-of-Pocket Maximum, you are generally only required to pay $800 per year for supplies and/or services that you receive from a PPO Provider (20% of $3,000 plus the $200 Deductible). The exception to this rule is that you are required to pay Copays for Hospital – Emergency Room Services, Physician Office Visits, and Routine Physical Exams regardless of whether you have reached your Annual Out-of-Pocket Maximum (i.e., you have to pay $800 per year plus any Copays charged for Hospital – Emergency Room Services, Physician Office Visits, and Routine Physical Exams). This Annual Out-of-Pocket Maximum limit has not changed.

On January 1, 2023, a "Supplemental Annual Out-of-Pocket Maximum" went into effect. The Supplemental Annual Out-of-Pocket Maximum is $4,550 per Covered Person and $9,100 per family. This means that if you have paid $4,550 for Covered Charges that you incurred for Comprehensive Medical Benefits provided by PPO Providers during a calendar year, then the Plan will pay 100% of the Covered Charges that you incur for Comprehensive Medical Benefits provided by PPO Providers during the remainder of the calendar year. Further, if your family has paid $9,100 for Covered Charges that your family incurred for Comprehensive Medical Benefits provided by PPO Providers in a calendar year, then the Plan will pay 100% of the Covered Charges that your family incurs for Comprehensive Medical Benefits provided by PPO Providers for the remainder of the calendar year. All the Copays, coinsurance and Deductibles that you pay for services provided by PPO Providers count towards the new Supplemental Annual Out-of-Pocket Maximum. The following Covered Charges do not count towards your Supplemental Annual Out-of-Pocket Maximum (i.e., the amounts that you pay for the following services do not count towards the $4,550 per person/$9,100 per family Supplemental Annual Out-of-Pocket Maximum):

- Covered Charges for services provided by a non-PPO Provider, unless those services are covered under the No Surprises Act as described in SMM 9 to your SPD; and
- Covered Charges paid for Dental Benefits, Vision Benefits or Prescription Drug Benefits.

The Supplemental Annual Out-of-Pocket Maximum was implemented to comply with the Affordable Care Act ("ACA"). The ACA limits are adjusted each year. Therefore, the Plan's Supplemental Annual Out-of-Pocket Maximum will change on January 1st of each year. The new amount will equal one-half of the maximum amount allowed by the ACA.

It is highly unlikely that the new Supplemental Annual Out-of-Pocket Maximum will impact the amount that you pay for the Covered Charges that you incur for Comprehensive Medical Benefits. That is because once you have reached the Annual Out-of-Pocket Maximum (i.e., the Annual Out-of-Pocket Maximum that is described in paragraphs one and two above and has been in place for decades), the only Covered Charges you have to pay for the services and supplies that you receive from PPO Providers are the $250 Copays for Hospital – Emergency Room Services and the $20 Copays for Physician Office Visits and Routine Physical Exams. This means that you would need to have a substantial amount of Hospital –

Emergency Room Services, Physician Office Visits, and/or Routine Physical Exams to reach the new Supplemental Annual Out-of-Pocket Maximum.

Examples:

These examples illustrate how the Annual Out-of-Pocket Maximum worked before the implementation of the Supplemental Annual Out-of-Pocket Maximum, and how the new Supplemental Annual Out-of-Pocket Maximum may reduce the amounts that you pay for benefits if you have an extremely high number of emergency room and/or physician office visits during a calendar year.

Example One: *Annual Out-of-Pocket Maximum Limit for Comprehensive Medical Benefits prior to January 1, 2023:*

Phillip is unmarried with no Dependents and has surgery with a PPO Provider on January 2, 2022. The Covered Charges for Phillip's surgery are $25,200. Once Phillip has met the $200 Deductible, the Plan covers Surgical Services of PPO Providers at 80% and thus will cover $20,000 of the cost for the surgery. As to the remaining $5,000 of the surgery bill, the Annual Out-of-Pocket Maximum limits Phillip's responsibility for the surgery to 20% of the first $3,000 of Covered Charges for the services of a PPO Provider, which is $600. This amount is added to the $200 Deductible, resulting in the amount of $800 as the total amount that Phillip will pay for the surgery.

Phillip visits a Hospital emergency room 20 times in 2022, resulting in a $250 Copay each time. Phillip is required to pay a total of $5,000 in Copays for Hospital – Emergency Room Services.

Phillip also visits physicians' offices 10 times in 2022, resulting in a $20 Copay each time. Phillip is required to pay a total of $200 in Copays for the Physician Office Visits.

The following table illustrates how the Annual Out-of-Pocket Maximum limit worked when the Supplemental Annual Out-of-Pocket Maximum did not apply:

Medical Claims	**Quantity**	**Phillip's Out-of-Pocket Costs**
Surgical Services	1	$800 which includes your $200 Deductible plus 20% coinsurance of $3,000
ER Visits	20	$5,000 with Copays of $250 per visit
Office Visits	10	$200 with Copays of $20 per visit
Total		**$6,000**

Thus, before application of the Supplemental Annual Out-of-Pocket Maximum limit, Phillip was required to pay $6,000 during the 2022 calendar year.

Example Two: *Annual Out-of-Pocket Maximum Combined with the Supplemental Annual Out-of-Pocket Maximum for Comprehensive Medical Benefits effective January 1, 2023:*

Phillip receives the same treatment in 2023 that he received in 2022. In other words, Phillip had the same surgery as described in the above example on January 2, 2023. Phillip also visited the Hospital emergency room 20 times in the first six months of the 2023 calendar year. Phillip then had 10 physicians' office visits in the second six months of the 2023 year.

Due to the new Supplemental Annual Out-of-Pocket Maximum, Phillip's cost for Hospital - Emergency Room Services is limited to $3,750 because he already incurred $800 of costs for the surgery ($200 Deductible plus 20% coinsurance of $3,000), and the total amount Phillip is required to pay is limited to

$4,550 in 2023. Further, by applying the Supplemental Annual Out-of-Pocket Maximum, Phillip pays nothing for the 10 physicians' office visits in the second half of 2023 because he already reached the Supplemental Annual Out-of-Pocket Maximum limit of $4,550 by the start of the second half of 2023.

The following table illustrates how the Supplemental Annual Out-of-Pocket Maximum works:

Medical Claims	Quantity	Phillip's Out-of-Pocket Costs
Surgical Services	1	$800 which includes your $200 Deductible plus 20% coinsurance of $3,000
ER Visits	20	$3,750 with Copays of $250 per visit
Office Visits	10	$0 with Copays of $20 per visit
Total		**$4,550**

Thus, by applying the Supplemental Annual Out-of-Pocket Maximum, Phillip's costs for the year are limited to $4,550. Therefore, Phillip will save approximately $1,450 due to the implementation of the Supplemental Out-of-Pocket Maximum.

3. Increase in Emergency Room Copay

Prior to January 1, 2023, the Copay for Hospital – Emergency Room Services was $80.

Effective January 1, 2023, the Copay for Hospital – Emergency Room Services is $250. This means, effective January 1, 2023, the Plan will pay the following percentages for Hospital – Emergency Room Services:

- After a Covered Person has met the Deductible and paid a $250 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 the Deductible and paid a $250 Copay, the Plan will pay 100% of Covered Charges for Hospital – Emergency Room Services provided by a non-PPO provider for the treatment of a Medical Emergency, and 80% of Covered Charges for Hospital – Emergency Room Services provided by a non-PPO provider for treatment other than for a Medical Emergency.

If you are admitted to the Hospital, then the $250 Copay is waived.

This change modifies the description of the Hospital – Emergency Room Services in the Summary of Benefits on page 9 of your SPD, the Comprehensive Medical Benefits Summary on page 48 of your SPD and the description of covered Hospital – Emergency Room Services in Section 2.17 of your SPD, as well as the description of the **Increase in Emergency Room Copay and New Rule for Items and Services Furnished at a Non-PPO Hospital or Facility for Medical Emergencies** on pages 3 and 4 of SMM 9 to your SPD.

4. New Coverage of Routine Preventive Care Services

Prior to January 1, 2023, the Plan covered some preventive services at no cost to you, and other preventive services at a cost to you.

Effective January 1, 2023, the Plan was amended to cover Routine Preventive Care Services provided by PPO Providers at no cost to you. "Routine Preventive Care Services" are defined as services that are considered preventive care under the ACA. The four areas of Routine Preventive Care Services under the ACA that are now covered by the Plan are as follows:

- Evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force;
- Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents; and
- Other evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women.

To find a current list of covered Routine Preventive Care Services, visit https://www.uhcprovider.com/content/dam/provider/docs/public/policies/index/commercial/preventive-care-services-01012023.pdf or contact the Fund Office.

Based on this change, the SPD has been amended as follows:

- For Routine Preventive Care Services provided by a PPO Provider, the Plan will pay 100% of Covered Charges without a Copay or Deductible.
- For Physician Office Visits and Routine Physical Examinations provided by a PPO Provider, the Plan will pay 100% of Covered Charges without a Copay or Deductible, if the visit is considered Routine Preventive Care under the ACA.
- For Well Child Care, the Plan will pay 100% of Covered Charges without a Copay or Deductible, if the Well Child Care is considered Routine Preventive Care Services under the ACA.

There is no change in the coverage of preventive care provided by non-PPO providers.

The changes relating to Routine Preventive Care Services impact the Summary of Benefits on page 9 of your SPD, the Comprehensive Medical Benefits Summary on page 49 of your SPD, and Sections 2.24, 2.25 and 2.31 of your SPD.

5. Prescription Drug Benefit Annual Out-of-Pocket Maximum

Prior to January 1, 2023, the Plan did not provide for a limit on the number of individual Copays that you are required to pay for Prescription Drug Benefits during a calendar year.

Effective January 1, 2023, the Plan was amended to provide for a "Prescription Drug Benefit Annual Out-of-Pocket Maximum." The Prescription Drug Benefit Annual Out-of-Pocket Maximum is $4,550 per Covered Person and $9,100 per family. This means that if you have paid $4,550 in Copays for Generic, Preferred Brand Drugs or Non-Preferred Brand Drugs, or for Specialty Drugs that are not in Sav-Rx's HIA Program and are purchased at a Sav-Rx Specialty Pharmacy, then the Plan will pay 100% of the charges you incur for those types of prescription drugs for the remainder of the calendar year. Further, if your family has paid $9,100 in Copays for Generic, Preferred Brand Drugs or Non-Preferred Brand Drugs, or for Specialty Drugs that are not in Sav-Rx's HIA Program and are purchased at a Sav-Rx Specialty Pharmacy, then the Plan will pay 100% of the charges your family incurs for those types of prescription drugs for the remainder of the calendar year.

The Prescription Drug Benefit Annual Out-of-Pocket Maximum is separate from the Annual Out-of-Pocket Maximum and Supplemental Annual Out-of-Pocket Maximum for Comprehensive Medical Benefits. This means that Covered Charges that you incur for Prescription Drug Benefits **do not** count

towards your Annual Out-of-Pocket Maximum and Supplemental Annual Out-of-Pocket Maximum for Comprehensive Medical Benefits.

The Prescription Drug Benefit Annual Out-of-Pocket Maximum was implemented to comply with the ACA. The ACA limits are adjusted each year. Therefore, the Plan's Prescription Drug Benefit Annual Out-of-Pocket Maximum will change on January 1st of each year. The new amount will equal one-half of the maximum amount allowed by the ACA.

6. <u>New Coverage of Routine Preventive Care Prescription Drug Benefits</u>

Effective January 1, 2023, the Plan was amended to cover "Routine Preventive Care Prescription Drugs" at no cost to you, as long as such drugs are purchased at retail pharmacies that participate in the Sav-Rx network. "Routine Preventive Care Prescription Drugs" are defined as drugs that are considered preventive care under the ACA.

Based on this change, the SPD has been amended to state that the Plan will cover Routine Preventive Care Prescription Drugs at 100%. The following rules will apply to this coverage:

- Routine Preventive Care Prescription Drugs are available for all Covered Persons, but different limitations apply depending on the specific Routine Preventive Care Prescription Drug. Additionally, only certain versions of Routine Preventive Care Prescription Drugs are covered by the Plan at 100%.
- Routine Preventive Care Prescription Drugs generally include only the following prescription drugs:
    - Generic Drugs;
    - Brand Drugs with no Generic Drug equivalents.

  Brand Drugs with a Generic Drug equivalent are not considered Routine Preventive Care Prescription Drugs and remain covered subject to the Plan's standard Copay, unless your Physician determines that a Brand Drug with a Generic Drug equivalent is medically necessary. If your Physician determines that a Brand Drug with a Generic Drug equivalent is medically necessary, your Physician can submit a letter of medical necessity to Sav-Rx for review. If your Physician submits a letter of medical necessity to Sav-Rx demonstrating that the Brand Drug is medically necessary for your prescription, the Plan will cover 100% of the cost of the Brand Drug.
- Routine Preventive Care Prescription Drugs that are statins are covered by the Plan at 100% if the statin is lovastatin, simvastatin, or pravastatin as referenced in the chart below. If you are taking a statin medication that is not lovastatin, simvastatin, or pravastatin, then the standard cost sharing will apply, unless your Physician determines it is medically necessary for you to take that statin. If your Physician determines that it is medically necessary for you to take a statin that is **<u>not</u>** lovastatin, simvastatin, or pravastatin, your Physician can submit a letter of medical necessity to Sav-Rx for review. If your Physician submits a letter of medical necessity to Sav-Rx demonstrating that the statin is medically necessary for your prescription, the Plan will cover 100% of the cost of the statin that is not lovastatin, simvastatin, or pravastatin.
- Routine Preventive Care Prescription Drugs purchased at a retail pharmacy that is not a Participating Pharmacy are not covered by the Plan at 100%. Instead, the standard cost sharing for Prescription Drugs will apply. In addition, the Plan will only reimburse you the amount that the Plan would have paid for the prescription if it was filled at a Participating Pharmacy. This means that in addition to the cost sharing, you will likely pay a higher amount because you will no longer have the advantage of the discounts available through Participating Pharmacies.
- Routine Preventive Care Prescription Drugs purchased at Walmart or Sam's Club will not be covered by the Plan.

The following table provides a list of Routine Preventive Care Prescription Drugs covered by the Plan and their limitations. If you do not meet the requirements and limitations described in the chart below, you will be responsible for the applicable cost sharing requirements listed in the chart at the beginning of Article III of the SPD, provided that the prescription drug is otherwise covered under Article III of the SPD. This list is subject to change.

INCLUDED SERVICES	COVERAGE DETAILS AND LIMITATIONS
Aspirin (Rx and OTC)	Men (ages 45-79) and women (ages 55-79); pregnant women at risk for preeclampsia
Colonoscopy Bowel Preparation	Men and women (ages 50 to 75)
Contraceptives	N/A
Erythromycin Ophthalmic Ointment	Infants under one year of age
Folic Acid (Rx and OTC)	Women capable of pregnancy
Immunizations	Preventive vaccines per guidelines for ages birth to 18 and adults
Iron (Rx and OTC)	Children ages 6 to 12 months
Oral fluorides (Rx only)	Children ages 6 months to 6 years
Raloxifene and Tamoxifen	Breast cancer prevention in high-risk women
Lovastatin, simvastatin, and pravastatin	Men and women ages 40-75 for primary cardiovascular disease prevention
Vitamin D	Men and women older than age 64
Tobacco cessation drugs (Rx and OTC)	Subject to a quantity limit of up to two quit attempts per calendar year for a 90-day treatment regimen. Tobacco cessation drugs in excess of two quit attempts per year are not Routine Preventive Care Prescription Drugs, but remain covered, subject to the applicable Prescription Drug Benefit Copay.

You can obtain a complete, up-to-date list of Routine Preventive Care Prescription Drugs covered by the Plan by contacting the Fund Office.

7. <u>New Plan Exclusions for Non-PPO Provider Rehabilitation Hospitals, Residential Treatment Facilities and Skilled Nursing Facilities</u>

Effective January 1, 2023, the Plan was amended to exclude from coverage certain services or treatment received at non-PPO Provider rehabilitation hospitals, residential treatment facilities, and Skilled Nursing Facilities, except as required by the No Surprises Act.

Based on this change, the following exclusion have been inserted in Section 8.01 of your SPD:

- Services or treatment at a non-PPO provider rehabilitation hospital, non-PPO provider residential treatment facility, or non-PPO provider Skilled Nursing Facility, except as required by the No Surprises Act.

Further, these amendments also modify the following portions of your SPD:

- The description of covered Hospital and Facility – Inpatient Services and Hospital and Facility – Outpatient Services on pages 9 and 48 and in Section 2.18 and 2.19 of your SPD; and
- The description of Skilled Nursing Facility Services on pages 9 and 49 of your SPD and in Section 2.27 of your SPD.

8. Limitation of Exclusion for Illegal Acts

Prior to March 16, 2020, Section 8.01(p) of the Plan contained an exclusion for treatment that results from acts of war or from participation in criminal activities. Effective March 16, 2020, the exclusion was amended to read as follows:

> Treatment that results from an act of war or treatment that results from a Covered Person's commission of or attempt to commit an illegal act which is considered a felony in the jurisdiction in which the act occurred and for which charges are brought against the Covered Person;

9. New Coverage of Telehealth Benefits

Effective January 1, 2022, the Plan was amended to provide coverage for telehealth benefits through providers other than Doctor on Demand. Based on this amendment, the exclusion in Section 8.01(o) was removed from your SPD. This means that the following coverage will be provided for telehealth visits, including telephone calls, telephone consultations, emails and/or email consultations, with providers other than Doctor on Demand:

- For telehealth visits provided by a PPO Provider, the Plan will pay 100% of the cost after you make the $20 Copay. The Deductible is waived.
- For telehealth visits provided by a non-PPO Provider, the Plan will pay 60% of the cost after Deductible.

If you receive telehealth benefits through Doctor on Demand, the Plan will continue to pay 100% of the Covered Charges for telehealth visits and you will not be required to pay a Copay, Deductible, or coinsurance.

10. New External Review for Adverse Benefit Determinations Related to Claims Involving Medical Judgment or a Recission of Coverage

Prior to January 1, 2023, if a claim for benefits (other than an adverse benefit determination relating to compliance with the No Surprises Act) 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. Your right to appeal an adverse benefit determination to the Trustees remains in effect and is reflected in Sections 9.06 and 9.08 of your SPD.

The Plan also provided that you may seek external review of your claim if the adverse benefit determination relates to compliance with the No Surprises Act. If you follow 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. These rules remain in effect and are reflected in paragraph 7 of SMM 9.

Effective January 1, 2023, the Plan was amended to provide an additional optional level of external review of your claim by an IRO. The new external review procedures apply if your claim was denied after you followed the Plan's internal claims and appeals procedures, you still disagree with the determination and your claim involves a "Medical Judgment" or a "Rescission of Coverage."

The IRO is composed of persons who are not employed by CompuSys, or any of its affiliates. There is no charge for this independent review process. The new level of external review is available for claims for Comprehensive Medical Benefits, Prescription Drug Benefits, Dental Benefits, Vision Benefits and HRA Benefits that involve a "Medical Judgment" or a "Recission of Coverage." External review is not available for adverse benefit determinations for claims relating to Death Benefits or Short-Term Disability Benefits.

Based on this change, Article IX of your SPD was amended by inserting the following Section 9.14:

Section 9.14 – External Review with Independent Review Organization ("IRO") for Adverse Benefit Determinations When a Claim Involves Medical Judgment or a Rescission of Coverage

If you followed the Plan's internal claims and appeals procedures described in this Article IX, you still disagree with the determination, and your claim involves a "Medical Judgment" or a "Rescission of Coverage," you may request that an IRO conduct an external review of your claim in accordance with this Section 9.14. Your claim will only qualify for external review if it relates to a claim involving a "Medical Judgement" or "Recission of Coverage" as described in Section 9.14(a), or 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.

External review is available for claims relating to Comprehensive Medical Benefits, Prescription Drug Benefits, Dental Benefits, Vision Benefits and HRA Benefits, but is not available for claims relating to Death Benefits or Short-Term Disability Benefits.

(a) Medical Judgment or Recission of Coverage

To be eligible for external review, your adverse benefit determination must involve a "Medical Judgement" or a "Recission of Coverage." This means your claim must involve at least one of the following:

(1) Medical Judgment

The term "Medical Judgment" means a determination based on, but not limited to, the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness.

(2) Recission of Coverage

The term "Recission of Coverage" means a determination involving a retroactive discontinuance of coverage, except as a result of your failure to timely pay required premiums or a discontinuance of coverage initiated by you.

(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 CompuSys 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). CompuSys 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

CompuSys 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 CompuSys in accordance with Section 9.14(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 involved a Medical Judgment or Recission of Coverage;
- 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 CompuSys' determination within a reasonable period of time, but no later than six business days after the date that CompuSys receives your request for external review.

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

If CompuSys 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 CompuSys 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 CompuSys needs additional information from you to determine whether or not your request is eligible for external review, CompuSys 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:

- CompuSys 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
- CompuSys 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 9.14(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, CompuSys 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 CompuSys within one business day after the date that the IRO receives this information. Upon receipt of this information, CompuSys may reconsider whether or not your claim is covered by the Plan. Reconsideration by CompuSys will not delay the external review. If CompuSys reconsiders your claim and, prior to the date that the IRO renders a determination, CompuSys determines that your claim is covered by the Plan, the external review will be terminated (i.e., if CompuSys determines that your claim is covered, it will no longer be necessary for the IRO to review your claim). If this occurs, CompuSys will provide you and the IRO with notice of its determination no later than one business day after the date that CompuSys 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 CompuSys' 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 Public Health Service Act to assist individuals with the internal claims and appeals and external review processes.

(6) Effect of IRO Determination

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

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

The IRO's determination is binding upon the Plan, CompuSys, 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.

11. Updated List of Trustees

Effective August 1, 2023, the names, titles, and addresses of the Plan's Trustees are as follows:

Union Trustees	Employer Trustees
Mr. Dave Reid IBEW Local 347 6809 S.E. Bellagio Ct. Ankeny, IA 50021	Ms. Angela S. Bowersox Iowa Chapter, NECA 8191 Birchwood Court, Suite G Johnston, IA 50131
Mr. Matt DeAngelo IBEW Local 347 6809 S.E. Bellagio Ct. Ankeny, IA 50021	Mr. Jim Davis The Waldinger Corporation 6200 Scout Trail Des Moines, IA 50321
Mr. Doug Wolf IBEW Local 347 6809 S.E. Bellagio Ct. Ankeny, IA 50021	Mr. John Irving Tri-City Electric Co. 1821 Ingersoll Avenue Des Moines, IA 50309
Mr. Matthew Warner IBEW Local 347 6809 S.E. Bellagio Ct. Ankeny, IA 50021	Mr. Joe Porepp The Waldinger Corporation 6200 Scout Trail Des Moines, IA 50321
Ms. Shannan Garza (Alternate) IBEW Local 347 6809 S.E. Bellagio Ct. Ankeny, IA 50021	Mr. Jamie Knutson (Alternate) Baker Group 1600 SE Corporate Woods Drive Ankeny, IA 50021-7501

The Board of Trustees may be contacted at the following address and phone number:

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PO Box 26068
Salt Lake City, UT 84126-0068
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