Electricians Health and Welfare Plan, IBEW 995
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NOTICE TO PARTICIPANTS OF MATERIAL BENEFIT MODIFICATIONS EFFECTIVE JANUARY 1, 2022

As Plan Sponsor, we monitor the benefits and financial experience of the Electricians Health and Welfare Plan, IBEW 995 ("Plan"), on an ongoing basis, to ensure that its assets are being used in a prudent manner that best serves the participants. Due to increased medical claims and decreased contributions during the pandemic, we find it necessary to implement benefit changes. As a result, the Plan will no longer have "grandfathered" status. We are also making changes to comply with recent federal legislation. This Notice is only a summary of these changes and does not replace or modify the Plan. For more information, please contact the Fund Office.

Increase in Deductible, Co-Payment Percentages and Out-of-Pocket Maximums

Before Amendment:

Calendar Year Deductible - $1,000 per person
Co-Payment Percentages - Network Providers - 85% (Plan) / 15% (Participant)
Out-of-Network Providers – 75% (Plan) / 25% (Participant)
Out-of-Pocket Maximums/calendar year - $2,700 per person & $5,400 per family

After Amendment:

Calendar Year Deductible - $3,000 per person
Co-Payment Percentages - Network Providers – 70% (Plan) / 30% (Participant)
Out-of-Network Providers – 50% (Plan)/ 50% (Participant)
Out-of-Pocket Maximums/calendar year - $5,000 per person & $10,000 per family

Benefits for Wellness and Preventive Services

Before Amendment:

The Plan covers the following tests and screenings at 100% with no Calendar Year Deductible, for both Network and Out-of-Network providers, when identified by the Physician as preventive and wellness services: (1) cholesterol tests/lipid panels; (2) complete blood counts; (3) chest x-rays; (4) electrocardiograms; (5) fecal blood tests; (6) gynecological exams; (7) immunizations; (8) diagnostic mammogams; (9) occult blood counts; (10) pap smears; (11) physical exams; (12) prostate testing; (13) sigmoidoscopies; (14) stress testing (not maternity); (15) urinalysis; (16) smoking cessation programs; (17) glucose, quantitative, blood; (18) general health panel; (19) basic metabolic panel; (20) thyroid stimulating hormone; and (21) hearing and vision testing as part of child's routine annual exam.

After Amendment:

The Plan will cover preventive and wellness services required by the Patient Protection and Affordable Care Act (ACA) at 100% with no Calendar Year Deductible, for Network providers only with the following exception. Covid-19 related preventive services, including immunizations, will be covered

for Network and Out-of-Network providers as required by law. There is a long list of preventive and wellness services covered by the ACA. It is reviewed and updated each year as needed. Covered services fall within the following categories:

(1) Services with an "A" or "B" rating recommended by the U.S. Preventive Services Task Force ("USPSTF"). Examples include screenings for breast cancer, cervical cancer, colorectal cancer, high blood pressure, type 2 diabetes mellitus, cholesterol, and child and adult obesity;

(2) 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;

(3) Preventive care and screenings for infants, children and adolescents as listed in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) including the American Academy of Pediatrics Bright Futures guidelines;

(4) Preventive care and screenings for women listed in comprehensive guidelines supported by HRSA (includes, for example, FDA-approved contraceptive methods and counseling, and gestational diabetes screening);

(5) Preventive care services for smoking cessation and tobacco cessation for Participants 18 years of age and older as recommended by USPSTF, including (i) counseling; and (ii) nicotine replacement therapy products prescribed by a Physician; and

(6) Over the counter items identified as an A or B recommendation by USPSTF when prescribed by a Physician.

Certain age, gender and quantity limitations apply. To check the current list of recommended services, visit the website for the United States Department of Health and Human Services at https://www.healthcare.gov/preventive-care-benefits/, or call the number on your Identification Card or the Fund Office for assistance. Generally, the Plan will cover the recommended preventive services effective for Plan Years beginning one year or later after issuance of the recommendation.

Expanded Coverage for Out-of-Network (OON) Providers

"General Rule" under Plan:

Out-of-Network providers or facilities ("OON Providers") are covered at the Out-of-Network Co-Payment Percentage rate (50%) applied to the Allowable Charge determined by the Plan, after satisfaction of the Calendar Year Deductible. In addition, Participants may be "balance-billed" by the OON Provider for the difference between its charges and the Plan's Allowable Charge. The Out-of-Pocket limit applies, and the Participant's cost-sharing (but not any balance-billed amounts) counts towards its satisfaction.

"Special Rule" Added to Prevent Surprise Medical Bills:

A "special rule" now applies in the three situations described below as required by recent law changes designed to prevent surprise medical bills. Otherwise, the "general rule" remains in effect.

Under the "special rule", OON Providers will be covered at the Network Co-Payment Percentage rate (Participant's share is 30%), applied to the Allowable Charge, after satisfaction of the Calendar Year Deductible. The Allowable Charge must be set according to new detailed rules. The Out-of-Pocket limit continues to apply, and the Participant's cost-sharing counts toward its satisfaction. Participants

may *not* be “balance-billed” by the OON Provider. Any payment disputes between the Plan and OON Provider must be handled through an Independent Dispute Resolution Process that does not involve the Participant. No pre-authorization is required for Emergency Services. In limited circumstances involving non-Emergency Services, Participants may knowingly waive these protections.

The three situations in which the “special rule” applies are as follows.

1. Emergency Services by Out-of-Network Providers for Emergency Medical Conditions

OON Providers of Emergency Services for Emergency Medical Conditions are subject to the “special rule”. An “Emergency Medical Condition” is a medical condition (including a mental health condition or substance use disorder), manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that not seeking immediate medical attention would place his or her health, or if pregnant the unborn child’s health, in serious jeopardy, impair bodily functions or result in serious dysfunction of a bodily organ or part.

“Emergency Services” include (i) a medical screening examination within the capability of a hospital’s emergency department or an independent freestanding emergency department and ancillary services routinely available in the emergency department to evaluate the Emergency Medical Condition, (ii) further examination and treatment required to stabilize the patient; and (iii) certain covered services provided after stabilization as part of outpatient observation or an inpatient or outpatient stay related to the emergency condition (unless there is notice and consent by the patient).

2. Non-Emergency Services by Out-of-Network Providers in Network Facilities

OON Providers of non-Emergency Services in a Network facility that are otherwise covered by the Plan are also subject to the “special rule”. For example, if a Participant receives covered medical treatment on an inpatient basis in a Network hospital which includes the medical services of an OON anesthesiologist or radiologist, the “special rule” applies for these OON Provider services.

3. *Out-of-Network Air Ambulance Services*

If a Participant receives air ambulance services from an OON Provider and the air ambulance services would be covered by the Plan if provided by a Network Provider, the “special rule” applies for these OON Provider services.

Claims and Claims Review Procedures

Claimants will have additional rights under the Plan’s Claims and Claims Review Procedures for Claims involving medical benefits. They are described below.

1. “Denial” will also include a rescission of coverage, which is a retroactive termination of coverage other than for non-payment, fraud or intentional misrepresentation, regardless of whether it impacts a particular benefit at that time.

2. Claims Procedure - For Claims Denied under the Claims Procedure, the written notice of Denial will also include (as applicable): (a) denial codes and Plan standards used in denying the Claim; (b) a description of the Plan’s internal appeals and external review processes; and (c) the availability and contact information for any ombudsman established to assist individuals with their internal claims and appeals and external review processes. Claimants may receive, free of charge, any new or additional evidence that is considered, relied upon or generated by the Plan for the Claim, and any new or

additional rationale relied upon in deciding the Claim. It must be provided as soon as possible and sufficiently in advance of when notice of the Claim determination is due to allow a reasonable opportunity to respond before that date.

3. Claims Review Procedure - For Claims Denied on appeal, the written notice of Denial will also include (as applicable) a statement of the right to request, free of charge, diagnosis, treatment and denial codes and their corresponding meaning; Plan standards used to Deny the Claim; information needed to perfect the Claim; a description of the Plan's External Review Process; and the availability with contact information for any ombudsman established to assist individuals with their internal claims, appeals and external review processes. A decision on review of any Claim in accordance with the Claims Review Procedure will be final and binding on all persons except as described in the "External Review of Claims" section.

4. External Review of Claims

(a) Claims Qualifying for External Review – After exhausting the Claims and Claims Review Procedure, a claimant may request further review by an Independent Review Organization ("IRO") for Denials that involve:

(i) Medical judgment such as medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational (the IRO will decide if a Denial involves a medical judgment); or

(ii) Rescission of coverage regardless of whether it impacts a particular benefit at that time.

(b) Deadlines for Filing Request for External Review and Preliminary Review –

(i) Written request is due four (4) months after receipt of Denial;

(ii) Plan has five (5) business days after receipt to complete a "**Preliminary Review**" to determine if claimant was covered when the health care service or item was requested or furnished, if the internal Claims and Review Procedures were exhausted (except in limited circumstances), and if a complete request has been submitted; and

(iii) Within one (1) business day of completing its Preliminary Review, Plan must notify claimant in writing as to whether the threshold requirements for external review have been met and, if not, the reasons why and any additional information that must be submitted to perfect the request.

(c) Review by Independent Review Organization (IRO) – If the request is complete and eligible, the Plan will assign it to an IRO. The IRO is not eligible for any financial incentive or payment based on the likelihood of its support of the Plan's Denial. The Plan will maintain contracts with more than one IRO and rotate assignments for external review. Once assigned, the following procedures apply:

(i) IRO will notify the claimant in writing as to eligibility and acceptance and how to submit additional information about the Claim;

(ii) Plan must timely provide to the IRO the documents and information it considered in making the Denial;

(iii) IRO will promptly forward to Plan any additional information submitted by claimant, and Plan may reconsider its Denial. If Plan reverses its Denial, written notice must be promptly provided to claimant and IRO, and IRO will terminate its external review;

(iv) If external review is not terminated, IRO will consider all information and documents timely received and decide the Claim on a de novo basis. IRO is bound by Plan's terms (unless contrary to law) and benefit requirements but not by decisions reached during its internal claims and appeal process. IRO may consider additional information if available and appropriate, recommendations or other information from treating health care providers, claimant or Plan, reports from appropriate health care officials or practice guidelines, Plan's clinical review criteria and the opinion of IRO's clinical reviewer, unless inconsistent with applicable law;

(v) IRO will provide written notice of its decision to claimant and Plan within 45 days after receipt of the request, with the following information unless inconsistent with applicable law: (I) general description of the reason for request for external review with sufficient information to identify the claim; (II) dates of receipt of the external review assignment and decision; (III) references to the evidence or documentation, including specific coverage provisions and evidence-based standards considered in reaching its decision; (IV) discussion of the principal reasons for its decision including the rationale and any evidence-based standards relied upon; (V) a statement that the decision is binding except to the extent remedies are available under State or Federal law; (VI) a statement that judicial review may be available; and (VII) current contact information for any office of health insurance consumer assistance or ombudsman established to assist with external review processes.

5. Expedited External Review of Claims

(a) Claims Qualifying for Expedited External Review – Claimants may request an expedited external review in the following circumstances:

(i) For an initial Claim Denial involving a medical condition where the timeframe to complete an expedited internal appeal would seriously jeopardize the claimant's life, health or ability to regain maximum function, and the claimant has filed an expedited internal appeal request; or

(ii) Claimant has received a final internal Claim Denial involving (I) a medical condition for which the timeframe for completing the standard external review would seriously jeopardize claimant's life, health or ability to regain maximum function, or (II) an admission, availability of care, continued stay, or health care item or service for which claimant received emergency services, but claimant has not been discharged from a facility;

(b) Preliminary Review – Immediately upon receipt of a request for expedited external review, the Plan will complete a Preliminary Review, as described above for a standard External Review, and immediately notify claimant as to whether the threshold requirements have been met or, if not, provide or seek the required information;

(c) Review by Independent Review Organization (IRO) – Upon determining that the expedited external review request qualifies, the Plan will assign an IRO and expeditiously provide all necessary documents and information it considered in denying the Claim. The IRO must consider all available information and documents and follow the review and notice content guidelines described above for a standard external review. Notice of its final external review decision must be given as expeditiously as the medical condition and circumstances require, but in no event more than 72 hours after the IRO's receipt of the request for review. If such notice is not given in writing, the IRO will provide written confirmation of its decision to the claimant and Plan withing 48 hours after giving the initial notice.

6. After Standard or Expedited External Review of Claims

If the IRO reverses the Plan's Denial, the Plan will immediately, upon receipt of the decision, provide coverage or payment for the reviewed Claim consistent therewith; however, the Plan may seek judicial remedy to reverse or modify the decision as permitted by law. If the IRO upholds the Plan's Denial, no coverage or payment will be provided by the Plan for the Denied Claim; however, the claimant may seek judicial review as permitted by ERISA Section 502(a).

Transparency in Plan ID Cards and Accuracy of Provider Directory Information

The Plan's Identification Card (ID Card) must now have additional information including a telephone number and website address for assistance. Participants will receive an updated ID Card to comply with these changes. The Plan will have a website for access to various Plan documents and notices.

There are new rules related to the need to have a current directory of Network Providers for Participants to review. The Plan's website will have a link to its Network Provider Database, which will include a list of all Network providers and facilities. It will be periodically reviewed, verified and updated as required by law.

Participants may call the Plan or consult the Database to determine if a particular provider or facility participates in the Plan's Network. The Plan will respond to Participant calls, as soon as practicable and no later than one business day after receipt, through a written electronic or print communication as requested by the Participant. Under certain circumstances, if a Participant receives incorrect information about the "Network" status of a provider or facility through the Database or call to the Plan and then receives covered medical services from it, the Plan may not charge the Participant higher cost-sharing than would apply for a Network provider or facility.

Continuity of Care Requirements

There are new patient protections for "continuing care patients" being treated by a Network provider or facility that ceases to participate in the Network during treatment. Generally, a "continuing care patient" is an individual who is (i) receiving treatment for a serious and complex condition, (ii) undergoing a course of inpatient care, (iii) scheduled for nonelective surgery, (iv) undergoing a course of treatment for pregnancy, or (v) receiving treatment for a terminal illness. The Plan must notify Participants who qualify of the right to elect continued transitional care, on a continued "Network" basis, for up to 90 days. Additional information is available from the Fund Office.

Clinical Trials

The Plan now covers participation by a qualified individual in an approved clinical trial for the treatment of cancer or other life-threatening disease or condition as required by law. There are certain conditions and limitations that apply. Additional information is available from the Fund Office.

Your receipt of this Notice is not a certification that you are eligible to receive any benefits under the Plan. You must satisfy the Plan's eligibility requirements to receive benefits. If you have any questions, please contact the Fund Office.

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