ELECTRICAL WELFARE TRUST FUND

SUMMARY OF MATERIAL MODIFICATIONS

The Board of Trustees of the Electrical Welfare Trust Fund ("Fund") has adopted the following changes to the Electrical Welfare Trust Fund's Summary Plan Description ("SPD"), effective January 1, 2022. These changes are designed to comply with the No Surprises Act of 2021, which was enacted to shield patients from the negative financial impacts of unexpected balance billing by non-network providers for certain medical claims such as those relating to emergency medical care. Please keep this document with your SPD and you Summary of Benefits and Coverage ("SBC").

1. The first two paragraphs of the Schedule of Benefits Section are deleted and replaced with the following:

> The following schedule shows the percentage of the "allowance" the Plan will pay for covered expenses. Your allowance is the Plan's pre-determined amount for a particular service. For most medical services, the Plan pays 80% of expenses after you've met your Annual Deductible. You are responsible for the other 20% (the Patient's Responsibility).
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> Effective January 1, 2022, the Patient's Responsibility for No Surprises Services will be determined based on the lesser of the Qualifying Payment Amount payable for such Services or the amount billed by the provider. Further, your Patient Responsibility payment for No Surprises Services will be counted towards your Deductible and Out-of-Pocket Maximum.
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> If you visit a provider in the UnitedHealthcare (UHC) network, the Allowance is accepted as payment in full for a particular service. In those cases, you will generally owe only the Patient's Responsibility to the participating provider. If your provider is not in the UHC network, you are responsible for paying any amount your provider charges above the allowance in addition to the Patient's Responsibility, unless the non-UHC provider's services are No Surprises Services.

2. In the Section entitled Understanding the EWTF Plan, the following is added:

> **Air Ambulance Services**
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> The No Surprises Act requires air ambulance services to be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the services had been furnished by an in-network provider. In general, you cannot be balance billed for these air ambulance services.
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> **Provider Directory**
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> The provider directory listing those providers that are in-network because they

participate in UHC's network will be updated at least every ninety (90) days and will be available through the Fund's website. If you receive services from a provider that you thought was in-network, based on inaccurate information in a current provider directory, then the services provided by that out-of-network provider will be covered as if the provider was in-network.

3. In the Section entitled Understanding the EWTF Plan, the following is added at the end of the first paragraph of the Plan General Exclusions Section:

These exclusions are applicable only to the extent they do not conflict with applicable law.

4. The Understanding Your Medical Benefits Section is revised to delete the second paragraph and replace it with the following:

After you meet your annual deductible, most covered services are paid at 80% of the allowance. Generally, you're responsible for paying the other 20% of the allowance—your Patient's Responsibility. However, effective January 1, 2022, your Patient's Responsibility for No Surprises Services will be determined based on the Qualifying Payment Amount. Further, your Patient Responsibility payment for No Surprises Services will be counted towards your deductible and out-of-pocket maximum.

If you visit a non-UHC provider, you may be responsible for additional expenses as well, including any amount billed by the provider that exceeds the allowance (balance billing), unless the non-UHC provider's services are No Surprises Services. If you receive services from a non-UHC provider that are not No Surprises Services but the services were provided under circumstances in which you did not have an opportunity to determine, and were not aware of, the provider's status as a non-UHC provider prior to receiving the services, then the Plan will treat the billed amount as the allowance and will pay 80% of such allowance. You will be responsible for the remaining 20%.

5. The second paragraph under the Section The Power to Save is deleted and replaced with the following:

For example: Let's say David has to go to the doctor to receive treatment that does not qualify as a No Surprises Service. The Plan has determined that the allowance for this service is $200 per visit, both in-network and out-of-network. The example below compares what the Plan pays and what David pays, in-network and out-of-network.

6. Your Medical Benefits is revised to include the following new section:

Continuing Care Patients

If an in-network provider leaves the network, a Continuing Care Patient who is

receiving care with that provider will be notified and may elect to continue receiving such care at the same in-network provider allowance and Patient Responsibility for up to 90 days after the provider leaves the network.

7. In the Section entitled Claims and Appeals Procedure, the following is added after the second paragraph of the Post-Service Timing Rules Section:

Notwithstanding the above, providers of No Surprises Services will receive payment, or a denial, of a post-service claim within 30 days of the Plan's receipt of all information necessary to adjudicate the claim.

8. In the Section entitled Claims and Appeals Procedure, the following is added before the Informal Review by UHC Section:

External Review of Denied Claims

If you receive a Final Internal Adverse Benefit Determination regarding a No Surprises Service, you may appeal that Determination to an external independent review organization (IRO). Claim denials for any service other than a No Surprises Service are not subject to external review.

A request for external review must be filed with the Plan within four months after you receive notice of the Final Internal Adverse Benefit Determination, or by the first day of the fifth month after you received the Final Internal Adverse Benefit Determination, if earlier.

Preliminary Review. Within five business days of receiving your external review request, the Fund and, if applicable, the IRO, will complete a preliminary review of your request to determine whether it is eligible for external review.

Within one business day after the preliminary review is complete, you will be advised of the decision. If your claim is not eligible for external review, the notice will state the reason(s) it is not eligible and will provide you with contact information for the Employee Benefits Security Administration. If your external review request is not complete, the notice will describe the information or materials needed to complete your request. You may submit the additional required information within the original four-month filing period or within the 48-hour period following your receipt of the preliminary review decision, whichever is later.

Referral to Independent Review Organization. If your external review request is complete and your claim is eligible for external review, your claim will be forwarded to an IRO for review. The IRO will notify you in writing that your claim has been accepted for external review and that you may submit to the IRO in writing, within ten business days, additional information for the IRO to consider when conducting its external review. The IRO may, but is not required to, accept and consider additional information submitted after ten business days.

If you choose to submit additional information, the IRO will forward the information to the Fund within one business day. The Fund then may reconsider its adverse benefit determination. However, reconsideration by the Fund will not delay the IRO's review. If the Fund decides to reverse its adverse benefit determination based on the additional information, the Fund will provide written notice of its decision to you and the assigned IRO within one business day after making such a decision. Upon receipt of such notice from the Fund, the assigned IRO will terminate the external review.

In making its decision, the IRO will review all of the information and documents it timely receives and will not be bound by any decisions or conclusions reached during the Fund's internal claims and appeals process. In addition, the IRO may consider additional information relating to your claim to the extent the information is available and the IRO considers it to be relevant.

The IRO will provide you with written notice of its external review decision within 45 days after receiving the request for the external review. The IRO's decision notice will contain:

1. A general description of the claim and the reason for the external review request, including the date(s) of service, the health care provider, the claim amount (if applicable), the diagnosis code, the treatment code and the reason for the previous denial);
2. The date the IRO received the external review assignment and the date of its decision;
3. Reference to the evidence considered in reaching its decision;
4. A discussion of the principal reason(s) for its decision, including any evidence-based standards that it relied on in making its decision;
5. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law;
6. A statement that judicial review may be available to you; and
7. Contact information for any applicable consumer assistance office.

Upon request, the IRO will make available to you its records relating to your request for external review, unless such disclosure would violate state or federal privacy laws.

Reversal of the Fund's decision. If the Fund receives a final external review decision that reverses its adverse benefit decision, the Fund immediately will provide coverage or payment of the claim in accordance with the terms of the Plan.

9. In the Section entitled Claims and Appeals Procedure, the following is added at the end of the Informal Review by UHC Section:

Please remember that if you are not able to resolve your concerns by contacting

UHC, you must appeal to the Board of Trustees before filing a suit against the Fund or, if applicable, requesting external review.

10. The following new definitions are added under the Glossary Section of your SPD:

Ancillary Services, with respect to an in-network Health Care Facility, means the following:

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

Continuing Care Patient means an individual who is: (1) receiving a course of treatment for a "serious and complex condition", (2) scheduled to undergo non-elective surgery (including any post-operative care); (3) pregnant and undergoing a course of treatment for the pregnancy; (4) determined to be terminally ill and receiving treatment for the illness; or (5) is undergoing a course of institutional or inpatient care from the provider or facility.

Emergency 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, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Final internal adverse benefit determination means the decision of the Board of Trustees on appeal regarding an adverse benefit determination.

Health Care Facility (for non-emergency services) means each of following:

1. A hospital;
2. A hospital outpatient department;
3. A critical access hospital; or
4. An ambulatory surgical center.

Independent Freestanding Emergency Department means a facility that is geographically separate and distinct from a hospital under applicable state law and provides, and is licensed under state law to provide, Emergency Services.

No Surprises Services means the following, to the extent covered under the Plan: (1) out-of-network Emergency Services, (2) out-of-network air ambulance services; (3) non-emergency ancillary services for anesthesiology, pathology, radiology, neonatology and diagnostics, when performed by an out-of-network provider at an in-network Health Care Facility; and (4) other out-of-network non-emergency services performed at an in-network Health Care Facility with respect to which the provider does not comply with federal Notice and Consent requirements.

Notice and Consent, with respect to out-of-network services provided at an in-network Health Care Facility, means: (1) that at least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), you are provided with a written notice, as required by federal law, that the provider is an out-of-network provider with respect to the Plan, the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, the names of any in-network providers at the facility who are able to treat you, and that you may elect to be referred to one of the in-network providers listed; and (2) you give informed Consent to continued treatment by the out-of-network provider, acknowledging that you understand that continued treatment by the out-of-network provider may result in greater cost to you. The Notice and Consent exception does not apply to Ancillary Services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the out-of-network provider satisfied the Notice and Consent criteria.

Qualifying Payment Amount generally means the median contracted rates of the Plan for the item or service in the geographic region. This amount is determined by the Plan and is subject to change.

Serious and Complex Condition means (1) In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (2) in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time.

11. Under the Glossary Section of your SPD, the definition of Co-Insurance is deleted, and the following definitions are deleted and replaced as follows:

Balance Billing – when a provider bills the patient for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill the patient for the remaining $30. A preferred provider may not balance bill a patient for covered services beyond the Patient Responsibility. Further, a non-participating provider may not balance bill a patient beyond the Patient Responsibility for any No

Surprises Services.

Emergency Room Care – Emergency Services you get in an emergency room or any facility that is geographically separate and distinct from a hospital and is licensed under state law to provide Emergency Services.

Emergency Services, with respect to an Emergency Condition, means any of the following:

1. An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an Independent Freestanding Emergency Department, including Ancillary Services routinely available to the emergency department to evaluate such emergency medical condition,
2. Such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished),
3. Services provided by an out-of-network provider or facility as part of outpatient observation or an inpatient or outpatient stay related to the emergency visit, until:
    - The provider or facility determines that you are able to travel using nonmedical transportation or nonemergency medical transportation; and
    - You are supplied with a written Notice, as required by federal law, that the provider is an out-of-network provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any in-network providers at the facility who are able to treat you, and that you may elect to be referred to one of the in-network providers listed; and
    - You give informed Consent to continued treatment by the nonparticipating provider, acknowledging that you understand that continued treatment by the out-of-network provider may result in greater cost to you.

Non-Participating Provider – a provider who doesn't have a contract with your Plan to provide services to you. You may pay more to see a non-participating provider, depending on the type of services.

Patient's Portion, Patient's Responsibility or Co-Insurance – your share of the costs of a covered health care service, generally calculated as a percent (for example, 20%) of the allowed amount for the service. You pay the Patient's Portion plus any deductibles you owe. Effective January 1, 2022, the Patient's Portion applicable to No Surprises Services is based on the lesser of the Qualifying Payment Amount payable for such Services or the amount billed by the provider. Your Patient's Portion for No Surprises Services will be counted towards your Deductible and Out-of-Pocket maximum.

Notice re Grandfathered Plan Status

The Electrical Welfare Trust Fund 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 the Electrical Welfare Trust Fund may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive 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 the telephone number listed below. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

If you have any questions, please contact the Fund Office at 1-800-929-3983**.**

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