ELECTRICAL WELFARE TRUST FUND

SUMMARY OF MATERIAL MODIFICATIONS

The Board of Trustees of the Electrical Welfare Trust Fund ("Fund") has made the following clarifying changes and benefit improvements to the Electrical Welfare Trust Fund's Plan document. Please keep this document with your Summary Plan Description ("SPD") and you Summary of Benefits and Coverage ("SBC").

Effective March 24, 2023, all references in the SPD to "substance misuse" are deleted and replaced with "substance use disorder."

Effective April 1, 2023, all references in the SPD to the "Healthy Pregnancy Program" are deleted and replaced with "Maternity Management Program."

Effective May 1, 2023, the reference to Telligen on page v of the SPD is deleted.

Effective May 1, 2023, the Weekly Accident and Sickness Benefits charts on pages 15 and 95 of your SPD are updated to reflect the following improvements to your benefits:

- For the first 13 weeks of disability, the benefit will be 50% of regular gross compensation, up to a maximum of $700 per week.
- For the second 13 weeks of disability (subject to Trustee approval), the benefit will be 40% of regular gross compensation, up to a maximum of $420 per week.

Effective April 1, 2023, the first two sentences under the Section titled "Routine Physical Exam for Member and Spouse" on page 64 of your SPD are revised to read as follows:

> You and your spouse are eligible for an annual physical exam. This annual exam, and any routine laboratory work conducted during such annual exam, will be covered at 100% with no cost sharing or deductible.

Effective April 1, 2023, the Section titled "Filing Your Benefits Claims," beginning on page 107, is revised as follows:

- The third, fifth, sixth and seventh bullets under the subsection titled "What You Need To Do" are revised to read:

    - Call UHC at 844-659-5060 or go to www.UMR.com to request claim forms if you are applying for reimbursement for charges incurred from a non-UHC medical or hospital provider.

    - Return the completed, signed form, along with any attachments to UHC at:

      UMR
      PO Box 30541

Salt Lake City, UT 84130-0541

- If you are applying for reimbursement for charges from a dentist, contact United Concordia Dental (UDC) at 1-866-851-7568 to request a claim form, and return the completed claim form to UDC at:

  United Concordia Companies, Inc.
  Dental Claims
  PO Box 69421
  Harrisburg, PA 17106-9421

- If you are a retired participant covered under Medicare, submit your claim and Medicare Explanation of Benefits to UHC at:

  UMR
  PO Box 30541
  Salt Lake City, UT 84130-0541

- The first paragraph under the subsection titled "Status of Claim" is revised to read:

  If you are calling UHC to check the status of your medical or hospital claim, United Concordia to check the status of your dental claim, or VSP to check the status of your optical claim, you will need to have the following information:

- The last sentence of the subsection titled "Contact with your Providers" is revised to read:

  For dental claims, your providers should contact United Concordia Dental (UCD). For Medicare claims, your providers should contact United HealthCare (UHC).

Effective April 1, 2023, the Section titled "Claims and Appeals Procedure," beginning on page 111, is revised to add the following language at the beginning of the Section:

As used in this Section of the SPD, references to the "Plan" may include the Fund's network providers, as appropriate, including UnitedHealthCare (also referred to as UHC or UMR) and United Concordia Dental (also referred to as UCD).

Effective April 1, 2023, the subsection titled "Informal Review by UHC" on page 117 of your SPD is revised to read as follows:

Review by UHC

Pre-Service Claims
If your pre-service claim for medical or hospital benefits is denied, before appealing that denial to the Board of Trustees as described above, you may submit a first level appeal to UHC.

You, your physician or your health care professional have the right to request the information reviewed to make this coverage decision free-of-charge. This includes reasonable access to and copies of all documents, records, health benefit plan provisions, internal rules, guidelines and protocols and any other relevant information. Please mail your request for this information to:

UMR Inc.
Attn: UMR Care Management
P.O. Box 8042
Wausau, WI 54402-8042

You have the right to be represented by someone else regarding this decision. To have someone else represent you, call us at the toll-free number on your member ID card and UHC will send you the form needed to designate another representative.

The following information is helpful to submit to UHC when appealing a pre-service claim denial:

- A written appeal request asking for reconsideration of the decision
- The specific coverage decision you would like to have reviewed
- An explanation of why the requested service should be considered for coverage
- Any additional information that supports your position
- A copy of the denial letter

Mail or fax this information to:

UHC Appeals – UMR, Inc.
P.O. Box 400046
San Antonio, TX 78229
FAX: 1-888-615-6584

The person who reviews your appeal will not be the person, or subordinate of that person, who made the original decision.

Typically, you have 180 days from your receipt of the claim denial letter to submit an appeal request. If you don't comply with these requirements, you may forfeit your right to appeal. When UHC receives an appeal request, it review the appeal within 15 calendar days and will notify you of its decision in writing.

If you submit a first level appeal of your pre-service claim to UHC and receive an adverse determination on appeal, you have the right to appeal the benefit denial to the Board of Trustees as described above. If you wish to file an appeal to the Board of Trustees, you must do so within 60 days from the day you received UHC's appeal denial. Please remember that if you are not able to resolve your concerns through your appeal to UHC, you must appeal to the Board of Trustees before filing a suit against the Fund.

Post-Service Claims

If your post-service claim for medical or hospital benefits is denied, before appealing that denial to the Board of Trustees as described above, you may contact UHC with any questions or concerns that you have regarding the claim denial. If you choose to do so, please contact the UHC directly at 1-800-850-1418 for important information regarding the appropriate procedures, including any time limits.

Whether or not you choose to address your concerns to UHC, you have the right to appeal a benefit denial to the Board of Trustees as described above. However, if you choose to address your concerns to UHC, you must do so before you appeal to the Board of Trustees and, if you are not satisfied with the results through UHC and wish to file an appeal to the Board of Trustees, you must do so within 180 days from the day you received the original claim denial. If you do not choose to address your concerns to UHC and wish to appeal directly to the Board of Trustees, you must do so within 180 days from the day you received the claim denial from the Fund Office. 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.

On page 133 of your SPD, the Section titled "Disclosures to Plan Sponsors," is clarified to read as follows:

Disclosures to Plan Sponsors

The Fund may disclose your health information to its Board of Trustees for purposes of administering the Plan. Any disclosure to the Trustees will be consistent with the Board of Trustees' powers, duties, and responsibilities under the Fund's Trust Agreement. The Trustees are bound by the Fund's privacy policies and procedures and may not re-disclose protected health information other than as permitted or required by the Plan and applicable law.

The Fund's privacy official shall be responsible for advising a Trustee of any perceived violation of the Fund's privacy policies and procedures. In the event the matter is not resolved to the satisfaction of the Fund's privacy official, the privacy official shall refer the matter to the Chairman of the Fund (or to the Co-Chairman if the Chairman is involved in the perceived violation), and if matter still is not resolved, to the full Board of Trustees. The Trustees certify that they have agreed to foregoing with respect to disclosure of protected health information.

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**.**

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