Amendment No. 3 to the 2020 Summary Plan Description and Plan Document of the NECA-IBEW Welfare Trust Fund

As Amended and Restated Effective July 1, 2020

WHEREAS, the Board of Trustees of the NECA-IBEW WELFARE TRUST FUND ("Fund") may, amend the NECA-IBEW Welfare Trust Fund Summary Plan Description (SPD) and Plan Document restated effective July 1, 2020; and

WHEREAS, the Trustees desire to amend the Plan to comply with the No Surprises Act (NSA);

NOW, THEREFORE, the Trustees amend the Plan as follows subject to the conditions specified above:

1. Effective July 1, 2022, the following definitions are added to the "Plan Definitions" section of SPD and Plan Document:

Air Ambulance Services: The term "Air Ambulance Service" means medical transport by helicopter or airplane for patients.

Ancillary Services: The term "Ancillary Services" with respect to a network facility including the following:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services and subject to exceptions specified by the Secretary; and
- Items and services provided by a Non-PPO provider if there is no PPO provider who can furnish such item or service at such facility.

Allowable Charges shall be amended by adding the following bullet point:

Notwithstanding the foregoing, if a Participant or Dependent receives Non-PPO Provider Emergency Services, Non-PPO Services at a PPO provider Hospital or Ambulatory Surgical Center, and Services from Non-PPO Air Ambulance Providers, then the Allowable Charge shall mean the amount that the Plan is required to pay under the *No Surprises Act,* as further described in the subsection entitled "Payments to Non-PPO Providers for No Surprises Act Claims" of the Section on "Protections from Surprise Medical Bills and Other Protections."

Cost-Sharing: The term "cost-sharing" includes Participant or Dependent copayments,

coinsurance, and deductibles.

Cost-Sharing Amount: The term "Cost-Sharing Amount" means the Participant's or Dependent's cost-sharing for Emergency Services, Non-emergency Services performed by Non-PPO providers at network facilities, and Air Ambulance services to be based on the Recognized Amount.

Emergency Department of a Hospital: The term "Emergency Department of a Hospital" includes a hospital outpatient department that provides Emergency Services.

Emergency Medical Condition: The term "Emergency Medical Condition" means a medical condition 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 that in the absence of immediate medical attention to place the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or serious impairment to bodily functions, or serious dysfunction of any bodily organ.

Emergency Services: The term "Emergency Services," with respect to an Emergency Medical Condition means –

- a medical screening examination (as required under Section 1867 of the Social Security Act, or as would be required under such Section if it applied to an Independent Freestanding Emergency Department) that is within the capability of the Emergency Department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including Ancillary Services routinely available to the Emergency Department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, to evaluate such Emergency Medical Condition; and

- within the capabilities of the staff and facilities available at the Emergency Department of a Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under Section 1867 of such Act, or as would be required under such Section if such Section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the Emergency Department of the Hospital in which such further examination or treatment is furnished).

The term "to stabilize" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an Emergency Medical Condition, to deliver a newborn child (including the placenta). Emergency Services furnished by a Non-PPO Provider or Non-PPO emergency facility (regardless of the department of the hospital in which such items or services are furnished) also includes post-stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the Emergency Medical Condition, until:

- The provider or facility determines you are able to travel using nonmedical transportation or nonemergency medical transportation;

- You are supplied with a written notice, as required by federal law, that the provider is a Non-PPO 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 PPO providers at the facility who are able to treat you, and that you may elect to be referred to one of the in-network or PPO providers listed; and

- You give informed consent to continued treatment by the Non-PPO Provider, acknowledging that the Participant or Dependent understands that continued treatment by the Non-PPO Provider may result in greater cost to the Participant or Dependent.

Independent Freestanding Emergency Department: The term "Independent Freestanding Emergency Department" means a health care facility that –

- is geographically separate and distinct and licensed separately from a hospital under applicable State law; and

- provides Emergency Services.

No Surprises Act: The term "No Surprises Act" means the federal No Surprises Act (Public Law 116-260, Division BB).

Qualifying Payment Amount (QPA): The term "Qualifying Payment Amount" of "QPA" means the amount calculated using the methodology described in 29 CFR 716-6(c) as required by the No Surprises Act.

Recognized Amount: The term "Recognized Amount" means, for items and services furnished by an out-of-network provider or out-of-network emergency facility, the Recognized Amount is one of the following:

- An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
- An amount determined by a specified state law; or
- The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA)

2. Effective July 1, 2022, Item 4 under Covered Medical Expenses on page 56 of the SPD and Plan Document shall be revised to read as follows:

Charges made by an emergency professional ambulance service for transportation (e.g., ground or air ambulance) to the nearest Hospital or Physician's office equipped to provide the required treatment for a life-threatening Injury or Sickness. In the case of a

terminal Illness, routine ground ambulance service to and from a Physician's office will also be covered. Any other transportation services are not covered.

3. Effective July 1, 2022, the section of the SPD and Plan Document entitled "Comprehensive Major Medical Benefit – Employees and Retirees Not Eligible for Medicare, and their Dependents" shall be amended at "How The Plan Works" under the "Emergency Room Deductible" subsection on page 53 by deleting the reference to "a Hospital Emergency Room" and replacing it with "an Emergency Department of a Hospital." The updated subsection will be as follows:

- **Emergency Room Deductible:** If you or your Dependents visit an Emergency Department of a Hospital for treatment of a Sickness or Injury not due to an accident, you are required to pay an additional Deductible (as shown in the applicable schedule in the "Schedules of Benefits" document) for each visit after the first two visits in a Calendar Year. This Deductible is in addition to the Calendar Year Deductible and any other Coinsurance or Copayment amounts you are responsible for paying. In addition, this emergency room Deductible does not apply toward meeting your Calendar Year Deductible or Out-of-Pocket Maximum, and you must pay this Deductible even after you have met your Out-of-Pocket Maximum.

4. Effective July 1, 2022, the Section of the SPD and Plan Document entitled "Comprehensive Major Medical Benefit – Employees and Retirees Not Eligible for Medicare, and their Dependents" shall be amended at "Preferred Provider Organization" on page 55 by adding the following to the end of the section:

Physicians, Doctor, Surgeon, or Hospitals not in the PPO network are known as "Non-PPO providers" or "out of network" providers.

For services on or after July 1, 2022, see the Section titled "Protections from Surprise Medical Bills and Other Provisions" in this SPD and Plan Document for more information on the *No Surprises Act*.

5. Effective July 1, 2022, the section of the SPD and Plan Document entitled "Comprehensive Major Medical Benefit – Employees and Retirees Not Eligible for Medicare, and their Dependents" shall be amended at "Covered Medical Expenses" subsection 39 in the 2nd paragraph on page 62 by deleting the reference to "an in-network master's-level provider with a" and replacing it with "a PPO provider with a master's-level " The updated 2nd paragraph will be as follows:

In order to be a Covered Expense, the Participant has undergone evaluation by a qualified mental health professional (QMHP) who is experienced in the evaluation and treatment of patients with a variety of mental health issues and has the requisite skill and experience in evaluation of patients with gender dysphoria and all relevant comorbid mental health conditions, including familiarity in the application of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V) or the then current version of the DSM. A practitioner will

be considered a QMHP if they are a board-certified psychiatrist or psychologist, or a PPO provider with a master's-level degree in a clinical behavioral science field from a nationally accredited credentialing board and appropriately licensed in the jurisdiction in which they practice and are qualified to evaluate and treat Participants as noted above. For the treatment of gender dysphoria to be considered a Covered Expense, the Participant must meet all criteria in the current version of the DSM and have no confounding comorbid mental health conditions, which would be contraindications to treatment, and treatment must have been recommended by a qualified practitioner with appropriate training and credentials. The approval of the practitioner is to be administered so it does not constitute a prohibited non-quantitative treatment limitation (NQTL) under the Mental Health Parity and Addiction Equity Act (MHPAEA) and the Plan imposes corresponding approval requirements for medical/surgical benefits.

6. Effective July 1, 2022, the section entitled "Other Plan Features" shall be amended by adding the following new section after the subsection entitled "Women's Health and Cancer Rights Act":

Protections from Surprise Medical Bills and Other Protections

In order to protect consumers from "surprise" medical bills, Congress passed the *Consolidated Appropriations Act, 2021 (CAA)* which contained the *No Surprises Act.* The *No Surprises Act* prohibits you from being "balance billed" for Non-PPO Emergency Services, certain services by Non-PPO providers at a PPO hospital or ambulatory surgical center, and by Non-PPO provider air ambulance services.

Prior to the new law, Non-PPO providers were permitted to bill you for the difference between what the Plan agreed to pay and the full amount the out-of-network providers or facilities charged for a service. This was called "balance billing."

"Surprise billing" is an unexpected "balance bill." This can happen when you have an emergency or when you schedule a visit at a PPO provider facility but are unexpectedly treated by a Non-PPO provider or use a Non-PPO provider air ambulance. The *No Surprises Act* prohibits Non-PPO providers or facilities from balance-billing you in such situations unless you are informed of your option to receive the Non-PPO services and consent to such and accept responsibility for any balance-billing.

In addition, the *No Surprises Act* added other patient protections concerning continuity of care, provider directories, and access to external review for denials related to surprise billing protections.

These new rules are effective beginning on or after July 1, 2022.

Protections Against Surprise Medical Bills

Non-PPO Provider Emergency Services

The Plan may not require preauthorization for PPO provider or Non-PPO provider Emergency

Services for an Emergency Medical Condition.

If you have an Emergency Medical Condition and receive Emergency Services from a Non-PPO provider or facility, the most the provider or facility may bill you is the Plan's in-network Cost-Sharing Amount (such as Copayments, Coinsurance and Deductibles). You can't be balance billed for these Emergency Services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

The Plan will pay the Non-PPO providers and facilities directly for their services in accordance with payment rules under the *No Surprises Act.* Any amount you pay for Emergency Services or Non-PPO services for claims covered by the No Surprises Act will apply toward your Deductible and Out-of-Pocket Maximum.

Non-PPO Services at a PPO Provider Hospital or Ambulatory Surgical Center

If you receive services from a PPO provider hospital or ambulatory surgical center, certain providers there may be a Non-PPO provider also providing services. In these cases, the most those Non-PPO providers may bill you is the Plan's in-network Cost-Sharing Amount (such as Copayments, Coinsurance and Deductibles). This applies to Ancillary Services, which generally include emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you wish to receive other services at these PPO provider facilities from Non-PPO providers you must give written consent to receive further medical treatment from them and pay Non-PPO charges for such treatment. In such situations, individuals will be provided information about their rights and how to provide written consent to receive further medical treatment and pay Non-PPO charges. If you consent to such Non-PPO treatment, then you give up your protections against balance billing.

The Plan will pay the Non-PPO providers and facilities directly for their services in accordance with payment rules under the *No Surprises Act.* Any amount you pay for Emergency Services or Non-PPO services will apply toward your Deductible and Out-of-Pocket Maximum.

When you may be billed for Non-PPO providers who work at PPO facilities

In certain circumstances, you can be billed by a Non-PPO provider who works at a PPO facility. This can occur if you are provided notice, as described below, that the provider is a Non-PPO provider and you give your informed consent to be treated by the out-of-network provider. The out-of-network provider must give you notice that:

- is in writing;
- is provided to you at least 72 hours before the day of the appointment or at least 3 hours in advance of services rendered for a same-day appointment;
- states the provider is an out-of-network provider;

- includes the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment;
- includes the names of any network provider at the facility who are able to treat you;
- provides that you may elect to be referred to a network provider; and
- your costs may be greater if you consent to service or treatment from the out-of-network provider.

If you give informed consent to be treated by the Non-PPO provider, then the Plan will pay for these services based on the Plan's Allowable Charge with respect to a Non-PPO Provider, and the provider can bill you for the balance directly. You may revoke your consent prior to the receipt of services.

This rule does not apply to services provided by hospital-based providers, such as anesthesiologists and radiologists, also referred to as Ancillary Services, or items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished for which a Non-PPO provider satisfied the notice and consent criteria described above. For Ancillary Services, your cost-sharing will be based on the Recognized Amount and any cost-sharing payments you make count toward your deductible and out-of-pocket maximum in the same manner as those received from a PPO provider.

Services from Non-PPO Air Ambulance Providers

If you receive services from a Non-PPO air ambulance provider, the most the Non-PPO air ambulance providers may bill you is the Plan's PPO provider Cost-Sharing Amount (such as Copayments, Coinsurance and Deductibles). Any amount you pay for Emergency Services or Non-PPO services will apply toward your Deductible and Out-of-Pocket Maximum.

Payments to Non-PPO Providers for No Surprises Act Claims

The Plan will make an initial payment or notice of denial of payment for Emergency Services, non-emergency services at network facilities by Non-PPO providers, and Air Ambulance Services within 30 calendar days of receiving a clean claim from the out-of-network provider. A "clean claim" is a claim that is accompanied by all information needed to decide, adjudicate or process the claim. The 30-day calendar period begins on the date the plan receives the information necessary to decide a claim for payment for the services.

If a claim relates to Emergency Services, Non-emergency services from an out-of-network provider at a network facility and Air Ambulance services from out-of-network provider, you cannot be required to pay more than the in network Cost-Sharing Amount under the Plan, and the provider or facility is prohibited from billing the Participant or Dependent in excess of the required Cost-Sharing Amount.

The Plan will pay a total plan payment directly to the Non-PPO provider that is equal to the amount by which the out-of-network rate for the services exceeds the Cost-Sharing Amount for the services, less any initial payment amount. The out-of-network rate means one of the following:

- the amount the parties negotiate;
- the amount approved under the independent dispute resolution (IDR) process; or
- if the state has an All-Payer Model Agreement, the amount that the state approves under that system.

Other Patient Protections

Continuity of Care

This section of the new law protects individuals receiving treatment from a provider or facility and is in need of continuing care in the event that provider or facility is no longer in the Plan's PPO-network of providers or facilities.

If you are receiving care from a PPO provider that becomes a Non-PPO provider, you may have certain rights to continue your course of treatment if you are a "continuing care patient."

A "continuing care patient" is a patient that:

a. is undergoing a course of treatment for a serious and complex condition from the provider or facility;
b. is undergoing a course of institutional or inpatient care from the provider or facility;
c. is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
d. is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
e. is or was determined to be terminally ill (as determined under Social Security Act) and is receiving treatment for such illness from such provider or facility.

A "serious and complex condition" means a condition that:

a. in the case of an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
b. in the case of a chronic illness or condition, a condition that:
    i. is life-threatening, degenerative, potentially disabling, or congenital; and
    ii. requires specialized medical care over a prolonged period of time.

If the Plan's contract with your PPO-Network provider or facility terminates or your benefits are terminated because of a change in terms of the providers' and/or facilities' participation in the PPO Network, you will be notified of the change and informed of your right to receive transitional care from the provider. You may choose to continue your course of treatment under the same terms and conditions as would have applied for a PPO-Network provider for up to 90 days after the notice is provided or until you no longer qualify as a continuing care patient (whichever is earlier). Providers cannot balance bill you during this time.

Termination of a contract includes the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

Choice of Health Care Professional

The Plan does not require the selection or designation of a primary care provider (PCP) or pediatrician. You have the ability to visit any network or out-of-network health care provider; however, payment by the Plan may be less for the use of an out-of-network provider.

Access to Obstetrical and Gynecological Care

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

Complaint Process

Any Participant or covered Dependent, or their authorized representative, may make a complaint or raise a concern relating to the Fund's processing of any of the above-described types of claims. The complaint or concern should be directed to Fund Administrator, Kevin Cope who is the designated Fund office contact to review all such complaints and concerns and address them in accordance with the requirements of the No Surprises Act and any other applicable law or regulations. Participants and covered Dependents also have a separate and independent right under the No Surprises Act to submit a complaint to the Department of Health and Human Services relating to the processing of the above-described types of claims. Participants and covered Dependents may also contact the Employee Benefit Security Administration (EBSA) toll free number at 1-866-444-3272.

Provider Directory

If you rely on information in the provider directory that inaccurately states that a Non-PPO provider is in the PPO network, or you have requested information on the network status of a provider or facility but did not receive a timely response you will only be subject to the PPO-network Cost-Sharing Amounts, even if the provider or facility is not in the PPO network.

External Review Process

The *No Surprises Act* requires grandfathered and non-grandfathered plans to provide for external review of adverse benefit determinations for claims subject to the cost-sharing and surprise billing protections in the *No Surprises Act*. Such items and services are those within the scope of the requirements for Non-PPO Emergency Services, nonemergency services performed by Non-PPO providers at PPO facilities, and Air Ambulance Services furnished by Non-PPO providers of Air Ambulance Services.

The Plan's external review rules shall apply to such claims described above.

The Plan's External Claims Appeal Procedures are intended to comply with 29 CFR 2590.715-2719. Accordingly, any requirement set therein but not otherwise includes in this document is incorporated by reference but only to the extent required by the applicable law.

7. Effective July 1, 2022, a new subsection entitled "External Review of Emergency Services, applicable Non-Emergency Services and/or Air Ambulance Services as required by the No Surprises Act" shall be added in the Claims and Appeals Procedures section after the "Medical Benefit Claims" subsection and before the Prescription Drug Benefit Claims" subsection:

External Review of Emergency Services, applicable Non-Emergency Services and/or Air Ambulance Services as required by the No Surprises Act

I. External Review of Standard Claims

This External Review procedure is applicable claims eligible for External Review as required by the No Surprises Act. Generally, this will pertain to denials related Emergency Service, applicable Non-Emergency Service and/or Air Ambulance Service claims as discussed in the section of this SPD entitled "Protections from Surprise Medical Bills and Other Protections." All other claims (*i.e., claims that are not covered by External Review requirements of the No Surprises Act*) are subject to the appeal procedures set forth on page 126 of the SPD.

Your request for external review of claims subject to the No Surprises Act, must be made, in writing, within four (4) months of the date that you receive notice of an initial adverse benefit determination or adverse Appeal Claim benefit determination. For convenience, these Determinations are referred to below as an "Adverse Determination," unless it is necessary to address them differently.

Because the Plan's internal review and appeals process generally must be exhausted before external review is available, in the normal course, external review of standard claims will only be available for Appeal Claim Benefit Determinations.

You do not need to exhaust the internal review and appeals process if the Plan fails to follow all the requirements for internal review. However, this does not apply to the Plan's minor violations of regulatory procedures or actions that are not prejudicial, are attributable to good cause, or are beyond the control of the Plan and made in the context of a good-faith exchange of information or are not reflective of a pattern or practice of non-compliance.

A. *Preliminary Review*

1. Within five business days of the Plan's receipt of your external review request for a standard claim, the Plan will complete a preliminary review of the request to determine whether:
    a. You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
    b. The Adverse Determination concerns a claim involving a claim eligible for External Review as required by the No Surprises Act.

c. The Adverse Determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan, or does not relate to a decision made solely on a legal or contractual interpretation of Plan terms;

d. You have exhausted the Plan's internal claims and appeals process (except in limited, exceptional circumstances); and

e. You have provided all the information and forms required to process an external review.

2. Within one (1) business day of completing its preliminary review, the Plan will notify you in writing as to whether your application meets the threshold requirements for external review. If applicable, this notification will inform you:

   a. If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

   b. If your request is not complete, in which case the notice will describe the information or materials needed to make the request complete, and allow you to perfect the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

B. ***Review by Independent Review Organization (IRO)***

If the request is complete and eligible, the Plan will assign the request to an IRO. The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The IRO must be accredited by URAC or similar nationally-recognized accrediting organization. The Plan will rotate assignment among at least three (3) IROs with which it contracts.

Once the claim is assigned to an IRO, the following procedure will apply:

1. The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim. Such additional information must be submitted within 10 business days. Information submitted after 10 business days may not be considered by the IRO.

2. Within five business days after the assignment to the IRO, the Plan will provide the IRO with the documents and information it considered in making its Adverse Determination.

3. If you submit additional information related to your claim, the assigned IRO must, within one (1) business day forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if, upon reconsideration, the Plan reverses its Adverse Determination, it will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

4. The IRO will review all the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo* (as if it were new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria, and/or the opinion of the IRO's clinical reviewer(s).
5. The assigned IRO will provide written notice of its final external review decision to you and the Plan within 45 days after the IRO receives the request for the external review.
6. The assigned IRO's decision notice will contain:
    a. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount [if applicable]), and the reason for the previous denial);
    b. The date that the IRO received the assignment to conduct the external review and the date of the IRO decision;
    c. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
    d. A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
    e. A statement that the determination is binding except to the extent that other remedies may be available to you or the Plan under applicable state or federal law;
    f. A statement of the opportunity to request the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
    g. A statement that judicial review may be available to you; and
    h. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

II. Expedited External Review of Claims

You may request an expedited external review if:

1. You receive an adverse Initial Claim Benefit Determination that involves a medical condition for which the time frame for completion of an expedited internal appeal would

seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or

2. You receive an adverse Appeal Claim Benefit Determination that involves a medical condition for which the time frame for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or you receive an adverse Appeal Claim Benefit Determination that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

A. *Preliminary Review*

Immediately upon receipt of the request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review set forth above, in section I.A.1, are met. The Plan will immediately notify you as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information described above in section I.A.2.

B. *Review By Independent Review Organization*

Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO. The Plan will expeditiously provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review, at the above section I.B. In reaching a decision, the assigned IRO must review the claim *de novo* (as if it were new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above in section I.B.6, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

III. After External Review

If the final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim.

If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

IV. Payment of Claims

The external review standards provide that an external review decision is binding on the Plan, as well as on the claimant, except to the extent other remedies are available under state or federal law. In addition, such otherwise binding decisions do not preclude the Plan from making payments on the claim or providing benefits to the claimant at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits. The Plan must provide benefits (including making payment on the claim) without delay pursuant to a final external review decision in the claimant's favor, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

V. Elimination of Conflict of Interest

To ensure that the persons involved with adjudicating claims and appeals (such as claims adjudicators and medical experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, or termination) or retention will not be made on the basis of whether that person is likely to support a denial of benefits.

8. Effective July 1, 2022, the Schedules of Benefits Revised February 2022, will be amended by adding "For services on or after July 1, 2022, see the Section titled Protections from Surprise Medical Bills and Other Provisions in the SPD and Plan Document for more information on the No Surprises Act." before each of the following Schedules of Benefits:

- Base Plan for Active Employees
- Alternative Plan for Active Employees
- Base Plan for Retired Employees Under Age 65
- Alternative Plan for Retired Employees Under Age 65
- Base Plan for Retired Employees Over Age 65 and Eligible for Medicare
- Alternative Plan for Retired Employees Over Age 65 and Eligible for Medicare
- Medicare Supplement Plan

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The above amendment to the NECA-IBEW WELFARE TRUST FUND's Summary Plan Description (SPD) and Plan Document was adopted by a Motion passed by the Board of Trustees on the 16th day of May, 2022. In witness hereof, the undersigned officers of the Board of Trustees affix their signatures hereto.

APPROVED:

DocuSigned by:
Mark Kawolsky
0C6363F7BFE3472...
Chairman

DocuSigned by:
Garrett Chan
9E0DD8DECA00453...
Secretary