IMPORTANT NOTICE ABOUT CHANGES TO YOUR HEALTH AND WELFARE PLAN

CEDAR RAPIDS ELECTRICAL WORKERS LOCAL #405 HEALTH AND WELFARE FUND

February 2022

Dear Participant:

The Board of Trustees ("Trustees") of the Cedar Rapids Electrical Workers Local #405 Health and Welfare Fund ("Plan") would like to inform you of important changes made to the Plan. This notification, which is called a Summary of Material Modifications ("SMM"), is intended to update the Plan's Summary Plan Description ("SPD") dated January 1, 2022. You should place this SMM with your SPD and retain it for future reference. If you do not have a copy of the January 1, 2022 SPD, please contact the Plan Administrative Manager at the address and telephone number noted below.

Please note that the receipt of this SMM is not a guarantee of coverage. You will only be eligible for the benefits described herein if contributions are required to be made to the Plan on your behalf.

UPDATED INFORMATION ABOUT LEGAL ACTION

The Trustees amended the Plan, effective September 9, 2022, to require that participants bring any legal action against the Plan or the Trustees in the United States District Court sitting in Des Moines, Iowa.

Accordingly, the SPD is updated as described below, effective September 9, 2022.

Paragraph 7, "Legal Action," within the "About This Summary Plan Description" section in the SPD is replaced in its entirety with the following:

7. **Legal Action**

   You cannot start any legal action against the Plan or the Trustees unless you have exhausted the applicable claims and appeals procedures and the external review process completely, as described in the Claim and Appeal Procedures section of this SPD. You cannot bring any legal or equitable action against the Plan or the Trustees because of a claim under the Plan, or because of the alleged breach of the Plan provisions, more than two years after the end of the calendar year in which the Plan provides an adverse appeal determination. Any claim that you may have relating to or arising under the Plan may only be brought in the U.S. District Court sitting in Des Moines, Iowa. No other court is a proper venue or forum for your claim. The U.S. District Court sitting in Des

Moines, Iowa will have personal jurisdiction over you and any other participant or beneficiary named in the action.

The Trustees also updated the SPD, effective January 1, 2022, to correct references to arbitration on page 107 of the Medical and Prescription Drug Benefits section. The paragraph previously titled "Arbitration and Legal Action" will read as follows:

Legal Action

You shall not start legal action against us until you have exhausted the appeal procedure described in this section. See the *About This Summary Plan Description* section and *Legal Action* for important information about your legal action rights after you have exhausted the appeal procedures in this section.

UPDATED INFORMATION ABOUT YOUR PLAN

New EAP Provider

The Trustees amended the Plan effective November 14, 2022 to use a new provider of Employee Assistance Benefits.

Accordingly, the SPD is updated as described below, effective as of November 14, 2022.

The "Provider of Employee Assistance Benefits" row within the "Your Plan Identification at a Glance" section in the SPD is revised to state:

Provider of Employee Assistance Benefits	Covenant Workplace Solutions, LLC 819 Fifth Street SE Cedar Rapids, IA 52401

Medical and Prescription Drug Benefits

The Trustees also updated the SPD to revise the following provisions within Section III, "Medical and Prescription Drug Benefits," effective January 1, 2023.

In Subsection C, "Details – Covered and Not Covered," select coverage descriptions (listed below) under the "Medical" header are revised to state:

Ambulance Services

Covered:

- Emergency air and ground ambulance transportation to a hospital. All of the following are required to qualify for benefits:
  - If you are inpatient, the services required to treat your illness or injury are not available where you are currently receiving care.
  - You are transported to the nearest hospital with adequate facilities to treat your medical condition.
  - During transport, your medical condition requires the services that are provided only by an air or ground ambulance.
  - Your medical condition requires immediate ambulance transport.

- In addition to the preceding requirements, for emergency air ambulance services to be covered, the following must be met:
  - Great distances, inaccessibility of the pickup location by a land vehicle, or other obstacles are involved in getting you to the nearest hospital with appropriate facilities for treatment by ground transport.

When the No Surprises Act applies to air ambulance services, you cannot be billed for the difference between the amount charged and the total amount paid by us.

In an emergency situation, if you cannot reasonably utilize a PPO ambulance service, covered services will be reimbursed as though they were received from a PPO ambulance service. However, if ground ambulance services are provided by an Out-of-Network Provider, and because we do not have contracts with Out-of-Network Providers and they may not accept our payment arrangements, you may be responsible for any difference between the amount charged and our amount paid for a covered service. When receiving ground ambulance services, select a provider who participates in your network to avoid being responsible for any difference between the billed charge and our settlement amount.

- Non-emergency air or ground ambulance transportation to a hospital or nursing facility. All of the following are required to qualify for benefits:
  - The services required to treat your illness or injury are not available where you are currently receiving care.
  - You are transported to the nearest hospital or nursing facility with adequate facilities to treat your medical condition.
  - During transport your medical condition requires the services that are provided only by an air or ground ambulance.
  - In addition to the preceding requirements, for non-emergency air ambulance services to be covered, all of the following must be met:
    - You must already be receiving care at a hospital.
    - Great distances, inaccessibility of the pickup location by a land vehicle, or other obstacles are involved in getting you to the nearest hospital or nursing facility with appropriate facilities for treatment by ground transport.

Not Covered:

- Air or ground ambulance transport from a facility capable of treating your condition.
- Air or ground ambulance transport to or from any location when you are physically and mentally capable of being a passenger in a private vehicle.
- Round-trip transports from your residence to a medical provider for an appointment or treatment and back to your residence.
- Air or ground transport when performed primarily for your convenience or the convenience of your family, physician, or other health care provider, such as a transfer to a hospital or facility that is closer to your home or family.
- Non-ambulance transport to any location for any reason. This includes private vehicle transport, commercial air transport, police transport, taxi, public transportation such as train or bus, ride-share vehicles such as Uber or Lyft, and vehicles such as vans or taxis that are equipped to transport stretchers or wheelchairs but are not professionally operated or staffed.

Autism Spectrum Disorder Treatment

Covered: Diagnosis and treatment of autism spectrum disorder and Applied Behavior Analysis services for the treatment of autism spectrum disorder when Applied Behavior Analysis services are performed or supervised by a licensed physician or psychologist or a master's or doctoral degree holder certified by the National Behavior Analyst Certification Board with a designation of board certified behavior analyst. Applied Behavior Analysis services are also covered for treatment of conditions other than autism spectrum disorder.

Emergency Services

Covered: When treatment is for a medical condition manifested by acute symptoms of sufficient severity, including pain, that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect absence of immediate medical attention to result in:

- Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

In an emergency situation, if you cannot reasonably reach a PPO Provider, covered services will be reimbursed as though they were received from a PPO Provider. When the No Surprises Act applies to emergency services, you cannot be billed for the difference between the amount charged and the total amount paid by us. If you receive medically necessary emergency services to treat an emergency medical condition, those services will be covered as required under the No Surprises Act notwithstanding any other plan exclusion.

See Also:
Out-of-Network Providers, page 67.

Fertility Services

Covered:

- Fertility prevention, such as tubal ligation (or its equivalent) or vasectomy (initial surgery only).

Not Covered:

- Services and supplies associated with an abortion that is elective (except abortions performed when the life of the mother is at risk if the pregnancy goes to full term and complications resulting from a noncovered abortion).

Hearing Services

Covered:

- Routine hearing examinations.
- Hearing aids, including related services and supplies, that are ordered by a provider within the scope of his or her license and there is a written prescription.
- Cochlear implants.

Benefits Maximum:

- **One** routine hearing examination per benefit year.

- **$2,500** every 36 months for hearing aids.

Not Covered:
- Hearing aids, including related services and supplies, that are not ordered by a provider within the scope of his or her license and there is not a written prescription.

Home/Durable Medical Equipment

Covered: Equipment that meets all of the following requirements:
- The equipment is ordered by a provider within the scope of his or her license and there is a written prescription.
- Durable enough to withstand repeated use.
- Primarily and customarily manufactured to serve a medical purpose.
- Used to serve a medical purpose.
- Standard or basic home/durable medical equipment that will adequately meet the medical needs and that does not have certain deluxe/luxury or convenience upgrade or add-on features.

In addition, we determine whether to pay the rental amount or the purchase price amount for an item, and we determine the length of any rental term. Wellmark requires rental of certain medically appropriate home/durable medical equipment including, but not limited to, continuous positive airway pressure (CPAP) devices. When rental is required, you will be required to rent from a licensed DME provider for a period of ten months, and after the expiration of the ten-month period, Wellmark considers the item purchased. Benefits will never exceed the lesser of the amount charged or the maximum allowable fee.

See Also:
Medical and Surgical Supplies and Personal Convenience Items later in this section.
Orthotics (Foot) later in this section.
Prosthetic Devices later in this section.

Infertility Treatment

Not Covered:
- Services and supplies associated with infertility diagnosis and treatment.
- Services and supplies associated with infertility treatment if the infertility is the result of voluntary sterilization.
- Services and supplies associated with infertility treatment related to the collection or purchase of donor semen (sperm) or oocytes (eggs); freezing and storage of sperm, oocytes, or embryos; surrogate parent services.
- Reversal of a tubal ligation (or its equivalent) or vasectomy.

Maternity Services

Covered: Prenatal care, delivery, and postpartum care, including complications of pregnancy. A complication of pregnancy refers to any maternity-related condition that is not diagnosed and coded as a normal prenatal visit or a normal spontaneous vaginal delivery.

Please note: You must notify us or your employer or group sponsor if you enter into an arrangement to provide surrogate parent services: Contact your employer or group sponsor or call the Customer Service number on your ID card.
In accordance with federal or applicable state law, maternity services include a minimum of:

- 48 hours of inpatient care (in addition to the day of delivery care) following a vaginal delivery, or
- 96 hours of inpatient care (in addition to the day of delivery) following a cesarean section.

A practitioner is not required to seek Wellmark's review in order to prescribe a length of stay of less than 48 or 96 hours. The attending practitioner, in consultation with the mother, may discharge the mother or newborn prior to 48 or 96 hours, as applicable. Coverage includes one follow-up postpartum home visit by a registered nurse (R.N.). This nurse must be from a home health agency under contract with Wellmark or employed by the delivering physician.

Not Covered: Maternity services for dependent children (with the exception of complications of pregnancy as described under *Covered*).

See Also:
Coverage Change Events, page 75.

Mental Health Services

Covered: Treatment for certain psychiatric, psychological, or emotional conditions as an inpatient or outpatient. Covered facilities for mental health services include licensed and accredited residential treatment facilities and community mental health centers.

To qualify for mental health treatment benefits, the following requirements must be met:

- The disorder is classified as a mental health condition in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-V) or subsequent revisions, except as otherwise provided in this benefits certificate.
- The disorder is listed only as a mental health condition and not dually listed elsewhere in the most current version of *International Classification of Diseases, Clinical Modification* used for diagnosis coding.

Licensed Psychiatric or Mental Health Treatment Program Services. Benefits are available for mental health treatment in the following settings:

- Treatment provided in an office visit, or outpatient setting;
- Treatment provided in an intensive outpatient setting;
- Treatment provided in an outpatient partial hospitalization setting;
- Individual, group, or family therapy provided in a clinically managed low intensity residential treatment setting, also known as supervised living;
- Treatment, including room and board, provided in a clinically managed medium or high intensity residential treatment setting;
- Psychiatric observation;
- Care provided in a psychiatric residential crisis program;
- Care provided in a medically monitored intensive inpatient setting; and
- For inpatient, medically managed acute care for patients whose condition requires the resources of an acute care general hospital or a medically managed inpatient treatment program.

Not Covered:

- Biofeedback.
- Services and supplies associated with certain disorders related to early childhood, such as academic underachievement disorder.
- Services and supplies associated with communication disorders, such as stuttering and stammering.
- Services and supplies associated with impulse control disorders.
- Services and supplies associated with conditions that are not pervasive developmental and learning disorders.
- Services and supplies associated with sensitivity, shyness, and social withdrawal disorders.
- Services and supplies associated with sexual disorders.
- Room and board provided while participating in a clinically managed low intensity residential treatment setting, also known as supervised living.
- Recreational activities or therapy, social activities, meals, excursions or other activities not considered clinical treatment, while participating in residential psychiatric treatment programs.

See Also:
Chemical Dependency Treatment and *Hospitals and Facilities* earlier in this section.

Preventive Care

Covered: Preventive care such as:

- Breastfeeding support, supplies, and one-on-one lactation consultant services, including counseling and education, provided during pregnancy and/or the duration of breastfeeding received from a provider acting within the scope of their licensure or certification under state law.
- Digital breast tomosynthesis (3D mammogram).
- Gynecological examinations.
- Mammograms.
- Medical evaluations and counseling for nicotine dependence per U.S. Preventive Services Task Force (USPSTF) guidelines.
- Pap smears.
- Physical examinations.
- Preventive items and services including, but not limited to:
  - Items or services with an "A" or "B" rating in the current recommendations of the United States Preventive Services Task Force (USPSTF);
  - Immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP);
  - Preventive care and screenings for infants, children and adolescents provided for in the guidelines supported by the Health Resources and Services Administration (HRSA); and
  - Preventive care and screenings for women provided for in guidelines supported by the HRSA.
- Well-child care including immunizations.

Benefits Maximum:

- Well-child care until the child reaches age 17.
- **One** routine physical examination per benefit year.
- **One** routine mammogram per benefit year.

- **One** routine gynecological examination per benefit year.

Please note: Physical examination limits do not include items or services with an "A" or "B" rating in the current recommendations of the USPSTF, immunizations as recommended by ACIP, and preventive care and screening guidelines supported by the HRSA, as described under *Covered*.

Not Covered:
- Periodic physicals or health examinations, screening procedures, or immunizations performed solely for school, sports, employment, insurance, licensing, or travel, or other administrative purposes.
- Group lactation consultant services.
- All services and supplies associated with nicotine dependence, except as described under *Covered*. For prescription drugs and devices used to treat nicotine dependence, including over-the-counter drugs prescribed by a physician, please see your Blue Rx Value Plus prescription drug benefits.

See Also:
Hearing Services earlier in this section.
Vision Services later in this section.

Temporomandibular Joint Disorder (TMD)
Covered.

Not Covered: Services and supplies associated with routine dental care, dental extractions, dental restorations, or orthodontic treatment for temporomandibular joint disorders.

Transplants
Covered:
- Certain bone marrow/stem cell transfers from a living donor.
- Heart.
- Heart and lung.
- Kidney.
- Liver.
- Lung.
- Pancreas.
- Simultaneous pancreas/kidney.
- Small bowel.

You are also covered for the medically necessary expenses of transporting the recipient when the transplant organ for the recipient is available for transplant.
Transplants are subject to care management.

Charges related to the donation of an organ are usually covered by the recipient's medical benefits plan. However, if donor charges are excluded by the recipient's plan, and you are a donor, the charges will be covered by your medical benefits.
Benefits Maximum:
- **$**5,000 per hospitalization for organ donor expenses.

Please note: To qualify for benefits, the transplant facility services specified under *Covered* must be from a facility recognized as a Blue Distinction® Center for Transplants at the time of service. This requirement does not apply to small bowel transplants or for practitioner services.

Not Covered:

- Expenses of transporting the recipient when the transplant organ for the recipient is not available for transplant.
- Expenses of transporting a living donor.
- Expenses related to the purchase of any organ.
- Services or supplies related to mechanical or non-human organs associated with transplants.
- Transplant services and supplies not listed in this section including complications.

See Also:
Ambulance Services earlier in this section.
Care Management, page 62.

Also in Subsection C, "Details – Covered and Not Covered," the following coverage description under the "Prescription Drugs" header now reads:

The Wellmark Blue Rx Value Plus Drug List
The Wellmark Blue Rx Value Plus Drug List is a reference list that includes generic and brand-name prescription drugs and pharmacy durable medical equipment devices that have been approved by the U.S. Food and Drug Administration (FDA) and are covered under your Blue Rx Value Plus prescription drug benefits. The Wellmark Blue Rx Value Plus Drug List is established and maintained by Wellmark's Pharmacy & Therapeutics (P&T) Committee. The P&T Committee is an independent group of practicing healthcare providers such as physicians and pharmacists who regularly meet to review the safety, effectiveness, and value of new and existing medications and make any necessary changes to the Drug List. The Drug List is updated following review by Wellmark's P&T Committee of FDA decisions or approvals on new and existing drugs. Changes to the Drug List may also occur when new versions or generic versions of existing drugs become available, new safety concerns arise, and as discontinued drugs are removed from the marketplace. Additional changes to the Drug List that could have an adverse financial impact to you (e.g., drug exclusion, drug moving to a higher payment tier/level) occur semi-annually.
To determine if a drug is covered, you must consult the Wellmark Blue Rx Value Plus Drug List. You are covered for drugs listed on the Wellmark Blue Rx Value Plus Drug List. If a drug is not on the Wellmark Blue Rx Value Plus Drug List, it is not covered.

If you need help determining if a particular drug is on the Drug List, ask your physician or pharmacist, visit our website, *Wellmark.com*, or call the Customer Service number on your ID card and request a copy of the Drug List.
The Drug List is subject to change.

In Subsection E, "Choosing a Provider," under the "Medical" header, the following new information is added before the "Provider Comparison Chart":

Blue Distinction Centers

Blue Distinction Centers (BDC) met overall quality measures, developed with input from the medical community. A local Blue Plan may require additional criteria for providers located in its own service area; for details, contact your local Blue Plan. Blue Distinction Centers+ (BDC+) also met cost measures that address consumers' need for affordable healthcare. Each provider's cost of care is evaluated using data from its local Blue Plan. Providers in California, Idaho, New York, Pennsylvania, and Washington may lie in two local Blue Plans' areas, resulting in two evaluations for cost of care; and their own local Blue Plans decide whether one or both cost of care evaluation(s) must meet BDC+ national criteria. National criteria for BDC and BDC+ are displayed on *www.bcbs.com*. Individual outcomes may vary. For details on a provider's in-network status or your own coverage, contact your local Blue Plan and ask your provider before making an appointment. Neither Blue Cross and Blue Shield Association nor any Blue Plans are responsible for noncovered charges or other losses or damages resulting from Blue Distinction or other provider finder information or care received from Blue Distinction or other providers.

In Subsection F, "Notification Requirements and Care Coordination," under the "Medical" header, the "Applies to" description for "Prior Approval" now also includes the following:

Please note: If a prior approval request is submitted for services that require a facility to have a Blue Distinction Center (BDC) designation for facility services to be covered, the prior approval request will be returned to your treating physician if the request is for facility services to be performed at a non-BDC facility. You should work with your treating physician to confirm the facility services for the planned procedure will be performed at a facility that has a BDC designation.

In Subsection G, "Factors Affecting What You Pay," under the "Medical" header, the third paragraph under "Benefit Year" is revised to state:

If you are an inpatient in a covered facility on the date of your annual benefit year renewal, your benefit limitations and payment obligations, including your deductible and out-of-pocket maximum, for facility services will refresh. This means that for facility services, as of your annual benefit year renewal, your benefit limitations and payment obligation amounts, including your deductible and out-of-pocket maximum, will be based on the amounts in effect on the date you were admitted. However, your payment obligations, including your deductible and out-of-pocket maximum, for practitioner services will be based on the payment obligation amounts in effect on the day you receive services.

Also in Subsection G, "Factors Affecting What You Pay," under the "Prescription Drugs" header, the second paragraph under "Participating vs. Nonparticipating Pharmacies" is revised to state:

Your payment obligation for the purchase of a covered prescription drug or pharmacy durable medical equipment device at a participating pharmacy is the lesser of your coinsurance, the maximum allowable fee, or the amount charged for the drug.

In Subsection H, "Claims," the second bullet point under "Request for Benefit Exception Review" is revised to state:

- FDA-approved or FDA-cleared contraceptive items or services prescribed by your health care provider based upon a specific determination of medical necessity for you.

In Subsection K, "General Provisions," the "Value Added or Innovative Benefits" subsection is revised to state:

Value Added or Innovative Benefits

Wellmark may, from time to time, make available to you certain value added or innovative benefits for a fee or for no fee. These value added or innovative benefits are not insurance and may be changed or eliminated at any time. Examples include Blue365®, identity theft protections, and discounts on alternative/preventive therapies, fitness, exercise and diet assistance, and elective procedures as well as resources to help you make more informed health decisions. Wellmark may also provide rewards or incentives under this plan if you participate in certain voluntary wellness activities or programs that encourage healthy behaviors. Your employer is responsible for any income and employment tax withholding, depositing and reporting obligations that may apply to the value of such rewards and incentives.

Finally, throughout Section III, "Medical and Prescription Drug Benefits," all references to a "nonparticipating provider" are updated to instead reference an "Out-of-Network Provider."

* * * * *

Please contact the Trustees in care of the Plan Administrative Manager at the following address and telephone number if you have any questions:

Cedar Rapids Electrical Workers Local #405 Health and Welfare Fund
c/o Auxiant
424 1st Avenue NE, Suite 200
Cedar Rapids, IA 52401
Phone: 319-398-3283
Toll Free: 800-475-2232

Sincerely,

BOARD OF TRUSTEES OF THE CEDAR RAPIDS
ELECTRICAL WORKERS LOCAL #405 HEALTH AND WELFARE FUND

This announcement, which serves as an SMM, contains only highlights of recent changes and certain features of the Plan. Full details are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the Plan document language will govern. The Trustees reserve the right to amend, modify, or terminate all or part of the Plan at any time.