AMENDMENT NUMBER 2
TO THE JANUARY 1, 2020, RESTATEMENT OF THE
RULES AND REGULATIONS
OF THE
CEMENT MASONS AND PLASTERERS
HEALTH AND WELFARE TRUST FOR
SOUTHERN NEVADA

The Rules and Regulations of the Cement Masons and Plasterers Health and Welfare Trust for Southern Nevada, (restated January 1, 2020), are hereby amended effective July 1, 2022, as follows:

PART 3, INDEMNITY MEDICAL BENEFITS, Section C, Deductibles and Copayments is amended to delete the lined-out text and add the underlined text shown below.

~~2. A $500 per visit Emergency Facility Copayment for Non-Emergency care ($0 for Emergency Care).~~ $0 for Emergency Care. The Plan covers Emergency Services for treatment of an Emergency Medical Condition in compliance with the No Surprises Act. An Emergency Medical Condition means a medical condition, including mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity 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 any of the conditions below:

1. Placing the health of the individual in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Effective July 1, 2022, emergency services will be covered:

a. Without prior authorization regardless of whether received In-Network or Out-of-Network;
b. Without regard as to whether provider furnishing the emergency service is a contract provider or a contract emergency facility, as applicable with respect to the services;
c. Without conditions such as denials based on final diagnosis codes;
d. Without regard to any other term or condition of the Plan or health insurance coverage other than the exclusion or coordination of benefits, any permissible waiting periods or applicable cost-sharing requirements
e. Without administrative requirements or limitations that are more restrictive than those applied to In-Network emergency services and facilities.

PART 3, INDEMNITY MEDICAL BENEFITS, Section D, Coinsurance and Annual Out-of-Pocket Maximums is amended to delete the lined-out text and add the underlined text shown below.

2. Annual Out-of-Pocket Maximums. The amount you pay each year in Copayments, Coinsurance and Deductibles on Essential Health Benefits delivered by PPO Providers will not exceed $3,500 per person or $10,5000 per family. Once you (or your family) meet the Annual Out-of-Pocket Maximum on Essential Health Benefits the Plan will not charge you any additional amounts for covered services. There is no Annual Out-of-Pocket Maximum for non-Emergency services provided by Non-PPO Providers. ~~The Annual Out-of-Pocket Maximum you will pay for Emergency Services Provided by Non-PPO Providers will not exceed the annual limit for PPO Provider services ($3,500 per person, $10,500 per family). Use PPO Providers when possible for non-Emergency Services in order to minimize your potential out-of-pocket expenses.~~

    a. Any cost-sharing for Out-of-Network emergency items and services will not be greater than the In-Network cost sharing amount that would apply had the items and services been provided by a participating provider or participating emergency facility;
    b. Any cost-sharing payments made by the Participant or Dependent will count towards the Plan's applicable deductible and Out-of-pocket maximums as if the items and services were provided by a participating provider or participating emergency facility.

PART 3, INDEMNITY MEDICAL BENEFITS, Section F, Covered Expenses is amended to delete the lined-out text and add the underlined text shown below.

b. **Non-Emergency Services Provided by Out-of-Network Provider at an in-Network Facility**. Effective July 1, 2022, medically necessary non-emergency items, services and visits that are otherwise covered by the Plan (which include equipment, devices, telemedicine, imaging, services, lab work, preoperative and postoperative services) performed by a non-contract provider at In-Network facilities (for which the Participant or Dependent has not knowingly and voluntarily provided consent pursuant to the No Surprise Act patient consent and notice requirements) are covered by the Plan as follows:

    i. Cost-sharing will not be greater than the In-Network cost sharing amount that would apply if the non-emergency items and services had been provided by a contract provider.
    ii. Any cost-sharing payments made by the Participant or Dependent will count towards, if any, the Plan's applicable deductible and Out-of-pocket maximums as if the non-emergency items and services were provided by a contract provider, and

iii. Non-emergency Health Care Facilities include hospitals (as defined in the Social Security Act Section 1861(e).

Participants and Dependents can knowingly and voluntarily agree to be balance billed including waiving the protections that limit cost-sharing for non-emergency services and post stabilization services provided the following informed patient and consent and notice requirements under the CAA Section 2799B-2(d) are met:

1. Notice and consent must be provided together and be physically separate from any other documents by provider/facility;
2. Must be provided at least 72 hours prior to the scheduled appointment, or if same day no later than 3 hours prior to appointment;
3. Notice and consent must list provider's name, good faith estimate for items or services reasonably expected to be provided, statement that patient is not required to consent (and may instead seek care from an available participating provider/facility and In-Network cost sharing will apply in such cases), and must be available in 15 most common languages in the geographic region;
4. Copy of signed consent must be provided to the patient via (in-person or through mail or email) method selected by patient.

However, providers/facilities cannot ask Participants and Dependents to give up protections not to be balance billed for:

1. Emergency services;
2. Air ambulance services;
3. Ancillary services at In-Network hospital or ambulatory surgical center, such as emergency medicine, anesthesiology, pathology, radiology, neonatology, assistant surgeon care, hospitalists, intensivists and diagnostic care such as radiology and lab work; and
4. Non-emergency services, if no In-Network provider is available or unforeseen urgent medical need or provider furnishes ancillary services that the patient typically does not select.

PART 3, INDEMNITY MEDICAL BENEFITS, Section F, Covered Expenses is amended to add the underlined text shown below.

30. Air Ambulance Service. Effective July 1, 2022, licensed air ambulance (meaning medical transport by a rotary-wing air ambulance or fixed-wing air ambulance including inter-facility transports) includes both In-Network and non-preferred provider air ambulance services are covered if the Plan determines that the location and nature of the illness or injury made air transportation cost effective or necessary to avoid the possibility of a serious complication or loss of life.

Effective July 1, 2022. New Section PART 15, LAWS THAT IMPACT YOUR BENEFITS, Section F, External Review Procedures is amended to add the underlined text shown below.

CONSOLIDATED APPROPRIATIONS ACT OF 2021 ("CAA")

Effective July 1, 2022, the Plan rules have been amended to comply with certain provisions of Division BB of the Consolidated Appropriations Act under the No Surprise Act (Title I) and Transparency (Title II) provisions, including any subsequent implementing regulations as it relates to the CAA.

1. **Identification Cards (CAA Section 107).** The Plan Identification Cards whether physical or electronic, issued to a Participant or its eligible Dependents will include: (a) the amount of the In-Network and Out-of-Network (if any) deductible and Out-of-pocket maximums, (b) telephone number and website address to seek further consumer assistance.

2. **Ensuring Continuity of Care (CAA Section 113).** When a provider or contracted facility is removed from the Plan or Insurer's (as applicable) coverage, following termination of the provider/facility contract between the Plan/Insurer and the provider/facility, the Plan (either TPA or Multiplan) will timely notify Participants or their eligible Dependents who are receiving continuing care for a serious and complex condition (serious and complex condition means an acute illness that is a condition that is serious enough to require specialized medical treatment to avoid reasonable possibility of death or permanent harm or in the case of chronic illness a condition that is life-threatening, degenerative, potentially disabling or congenital and requires specialized medical care over a prolonged period of time) from that provider or facility that: (a) the provider/facility is no longer part of the Plan's network and (2) the Participant or eligible Dependent has the right to continue receiving transitional care for up to ninety (90) days at the In-Network cost sharing and at the same terms that would have applied had termination not occurred.

3. **Accuracy of Provider Directory Information (CAA Section 116)**

    a. Verification Process. Not less frequently than once every ninety (90) days the Plan through Multiplan or Insurer (as applicable) will verify and update its provider directory information included on the Multiplan or Insurer's database. Providers are required to submit regular updates to the Plan to assist with the verification and update process, including notice of material changes to their provider directory information. The database of provider directories must then be updated within two (2) business days of the Plan receiving such data from the providers.

    b. Response Protocol. The Plan through Multiplan will respond to a Participant or Dependent's request (whether by telephone, electronic, web-based or internet-based), within one (1) business day of the request, about a

provider's network status. The Plan must also retain communication records for two (2) years.

c. Database. The Plan through Multiplan or Insurer (as applicable) will maintain a public website directory that contains a list of each of its contracted and facility providers, relevant information (name, address, specialty, number, digital contact information) and post information on balance billing protections and appropriate federal and state agency contacts to report violations.

d. Cost-Sharing for Services Provided Based on Reliance on Incorrect Provider Network Information. If a Participant or Dependent provides documentation (ex. received through database, provider directory or response protocol) that he/she received and relied on incorrect information from the Plan through Multiplan about a provider's network status prior to the visit and the item or services would otherwise be covered under the Plan if furnished by a participating provider/facility, the Plan through Multiplan cannot impose cost-sharing amount greater than In-Network rates and it must count towards the Participant or Dependent's In-Network Out-of-pocket maximum and In-Network deductible. If a provider submits a bill to an enrollee in excess of the In-Network cost-sharing amount and the enrollee pays, the provider must refund that excess amount with interest.

4. **Surprise Billing Protections (CAA Sections 102 and 105).**
   a. Balance Billing Prohibition. Participants and Dependents are prohibited from being balance billed for (1) **Out-of-Network emergency services**, (2) **non-emergency services performed by an Out-of-Network provider received at In-Network facility**, and (3) **Out-of-Network air ambulance services**. Providers are prohibited from holding patients liable for excess amounts not covered by the Plan.
   b. Cost-Sharing Limits. In addition, for the three above-mentioned surprise items and services (#1, #2 and #3) any cost-sharing (such as copayment, coinsurance or deductible) must not be greater than the In-Network cost sharing amount and must count towards the Plan's In-Network deductible and Out-of-pocket maximums, as if the items and services were provided by a participating provider. The Participant or Dependent's cost-sharing is based on the **Recognized Amount**. By statute, the recognized amount is (in order of priority) for only Out-of-Network emergency services and non-emergency services provided by an Out-of-Network provider at participating facilities:
      1. Amount determined by All-Payer Model Agreement, if applicable:
      2. Amount under specified state law;
      3. The lesser of the billed charge or Qualifying Payment Amount (is the median of the contracted rates for similar

services in a particular geographic area-based on the metropolitan statistical area adjusted by the consumer price index for inflation for items or services furnished during 2023 or subsequent years).

For Out-of-Network air ambulance bills the cost-sharing limit must be calculated by using the lesser of the: (1) billed charge or (2) Qualifying Payment Amount.

c. Determination of Out-of-Network Rates. By statute, the total amount to be paid to a provider/facility must be based on (less any cost-sharing from Participant or Dependent) the following Out-of-Network rate, in order of priority:

1. Amount determined by All-Payer Model agreement, if applicable;
2. Amount under specified state law (as applied to plans regulated by state law);
3. Amount agreed upon by Plan/Insurer and Provider/Facility; and
4. Amount determined by Independent Dispute Resolution Entity.

5. **Patient Protections Disclosure Requirements Against Balance Billing.** Plans and Insurers (if applicable) are required to make publicly available, by posting on the website of the Plan or Insurer and including on each Explanation of Benefits for an item or service as it relates to: (1) emergency services or (2) non-emergency services provided by non-participating provider at In-Network facility, balance billing and patient protections in certain circumstances and appropriate government agency contact information if the Participant or Dependent believes the provider/facility has violated the No Surprise Act provisions.

6. **Out-of-Network Rate Independent Dispute Resolution Process for Certain No Surprise Act Items and Services (CAA Section 103.** A federal Independent Dispute Resolution ("IDR") process is required for disputes involving Out-of-Network rates between the Plan/Insurer and Out-of-Network provider/facility ("disputing parties") as it relates only to:

1. Out-of-Network emergency services,
2. Non-emergency services provided by a non-network provider at an in-network facility and
3. Out-of-Network air ambulance services.

Not all items and services are eligible for the federal IDR process. But, before initiating the IDR process, the disputing parties must first initiate a 30-day open negotiation period (meaning must engage in open negotiations within 30 calendar

days of receiving initial payment or denial) to settle an Out-of-Network payment rate for covered items and services under the No Surprise Act. 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 is subject to the No Surprises Act, the Participant cannot be required to pay more than the cost-sharing under the Plan, and the provider or facility is prohibited from billing the Participant or Dependent in excess of the required cost-sharing.
If an Out-of-Network provider or facility and the Plan enter into the Independent Dispute Resolution (IDR) process under the federal No Surprises Act (Public Law 116-260, Division BB) and do not agree before the date on which a certified IDR entity makes a determination with respect to such item or service, the allowable amount is the amount of such determination.
In case of a failed open negotiation period, either party may initiate the federal IDR process as follows:

Independent Dispute Resolution	**Timeline**
Initiate **30 business day** open negotiation period	**30 business days** starts on date of initial payment or notice of denial of payment
Initiate IDR process following failed open negotiation	**4 business days** starts the business day after open negotiation period ends
Mutual Agreement on certified IDR entity selection	**3 business days** after IDR initiation date
Departments select certified IDR entity in the case of no conflict-free selection by the parties	**6 business days** after the IDR initiation date
Submit payment offers and additional information to certified IDR entity	**10 business days** after date of certified IDR entity selection
Payment determinations made (*certified IDR issue binding determination selecting one of the parties' offers as the payment amount*)	**30 business days** after the date of certified IDR entity selection
Payment submitted to the applicable party	**30 business days** after the payment determination

Both parties are responsible for an administrative fee and the non-prevailing party is responsible for the certified IDR entity fee for the use of this process. The 2022 administrative fee and allowable IDR entity fee ranges are available at: Calendar Year 2022 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act (cms.gov)

Batched Items and Services. Batching means multiple items or services that are considered jointly as part of one payment determination by a certified IDR entity

for purposes of the federal IDR process. Batching is also allowed for claims submitted within a 30-day period that meet the following criteria:

- Services furnished by the same provider or facility
- Services provided to Participants and Dependents under the same plan
- Services for treatment of similar conditions.

The party that initiated the IDR process cannot initiate a new IDR process with the same party and for same services for 90 days. However, when on the 90 day period is up, the party may submit (appropriately batched) claims from that 90-day period to IDR.

Factors Considered by IDR Entity. When making a payment determination, the certified IDR entities must begin with the presumption that the Qualifying Payment Amount is the appropriate Out-of-Network amount. If a party submits additional information that is allowed under the statute, then the certified IDR entity must consider the information if it is credible. For the IDR entity to deviate from the offer closest to the Qualifying Payment Amount, any information submitted must clearly demonstrate that the value of the item or services is materially different from the Qualifying Payment Amount.

Within 30 days, the IDR entity selects one of the offers submitted and must consider

- Offers by both parties; and
- Qualifying Payment Amount for the same service in the same geographic region.

The IRD entity can also consider the following factors:

- Training, experience, quality, and outcomes measurements;
- Market shares of parties;
- Acuity of patients/complexity of cases;
- Teaching status, case mix, scope of services of facility; and
- Good faith efforts by parties to contract and contracting rate history from last four years.

The IDR entity cannot consider:

- Usual and customary rates;
- Billed charges; and
- Payment rates by public payors, including Medicare, Medicaid, CHIP and Tricare.

Effective July 1, 2022. New Section PART 16, CLAIMS AND APPEALS PROCEDURES, Section N, External Review Procedures is amended to add the underlined text shown below.

N. External Review Procedures.

1. **External Review of Certain No Surprise Act Claims (CAA Section 110).** This External Review process is intended to comply with the No Surprises Act External Review requirements. The Plan will comply with an applicable External Review process, as described in 26 CFR 54.9815-2719(d), 29 CFR 2590.715-2719(d), and 45 CFR 147.136(d) and any subsequent implementing regulations. As such, eligible Participants and Dependents have the right to request External Review after he/she has exhausted the Plan's current internal claims and appeals rules, upon receipt of an adverse benefit determination as it relates to whether the Plan is complying with the surprise billing and cost-sharing protections under the No Surprises Act and its implementing regulations for certain No Surprise Act claims and services mentioned in this section. This means that, generally, you may only seek External Review after a final determination has been made on your appeal. External Review is available only with respect to the following types of claims (whether urgent, concurrent, pre-service or post-service claim is denied):

1. Out-of-Network emergency services.
2. Non-emergency services provided by a non-network provider at an In-Network facility and
3. Out-of-Network air ambulance services.

External Review is permitted only in certain cases for adverse benefit determinations (including a final internal adverse benefit determination) by the Plan or insurer that involves medical judgment, including but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, as well as a consideration of whether the Plan is complying with the surprise billing and cost sharing protections under ERISA sections 716 and 717 and §§ 2590.716-4 through 2590.716-5 and 2590.717-1.

To illustrate, the scope of claims eligible for External Review include:

i. Whether a particular item or service constitutes treatment for emergency services.
ii. Whether services provided by an Out-of-Network provider at an in In-Network facility is subject to the No Surprise Act.
iii. Whether an individual was in a condition to receive Patient protection notice under the No Surprise Act and able to waive the right to those protections.
iv. Whether a provider has coded the claim correctly, consistent with the treatment the patient actually received.
v. Whether cost-sharing was appropriately calculated for claims for ancillary services provided by an Out-of-Network provider at an In-Network facility.

External Review is not available for any other types of denials, including if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the

Plan. There is no cost to you to request External Review. The Plan assumes responsibility for fees associated with External Reviews outlined in this document.

There are two types of External Claims outlined below: Standard (Non-Urgent) Claims and Expedited Urgent Care Claims.

1. External Review of Standard Claims

   a. Your request for External Review of a standard (non-urgent) claim must be made, in writing, within four (4) months of the date that you receive notice of a Claim Appeal Benefit Determination. For convenience, these Determinations are referred to below as an "Adverse Determination", unless it is necessary to address them separately.

   b. Within five (5) business days of the Plan's receipt of your request for an External Review of a standard claim, the Plan will complete a preliminary review of the request to determine whether:
      i. You are/were covered under the Plan at the time of 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 of the health care item or service provided;
      ii. The Adverse Benefit Determination satisfies the above-stated requirements for External Review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan.
      iii. You have exhausted the Plan's internal claims and appeals process; and
      iv. You have provided all of the information and forms required to process an External Review.

   c. Within one (1) business day of completing its preliminary review, the Plan will notify you in writing as to whether your request for External Review meets the above requirements for External Review. This notification will inform you:

      i. If your request is complete and eligible for External Review; or
      ii. If 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)).
      iii. If your request is not complete (incomplete), the notice will describe the information or materials needed to complete the request, and allow you to perfect (complete) 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.

   d. Review of Standard Claims by an Independent Review Organization (IRO). If the request is complete and eligible for an External Review, the Plan will assign the request to an IRO. (Note that 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 Plan may rotate assignment among IROs with which it contracts.) Once the claim is assigned to an IRO, the following procedure will apply:

i. 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 (generally, you are to submit such information within ten (10) business days).

ii. Within five (5) business days after the External Review is assigned to the IRO, the Plan will provide the IRO with the documents and information the Plan considered in making its Adverse Determination.

iii. If you submit additional information related to your claim to the IRO, 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, the Plan 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.

iv. The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo* (as if it is 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, recommendations or other information from your treating (attending) health care providers, other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

v. 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.

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

However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

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)].

vi. The assigned IRO's Decision notice will contain:

7. 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, health care provider, claim amount (if applicable), diagnosis code and its corresponding meaning, and treatment code and its corresponding meaning, and reason for the previous denial);
8. The date that the IRO received the request to conduct the External Review and the date of the IRO decision;
9. References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence- based standards;
10. A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;
11. A statement that the IRO's determination is binding on the Plan (unless other remedies may be available to you or the Plan under applicable State or Federal law);
12. A statement that judicial review may be available to you; and
13. 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.

2. **External Review of Expedited Urgent Care Claims**

a. You may request an expedited External Review if: 1) you receive an adverse Initial Claim Appeal Benefit Determination that involves a medical condition for which the timeframe 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 timeframe 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 Claim Appeal 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.

b. Preliminary Review for an Expedited Claim. 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 are

met (as described under Standard claims above). The Plan will immediately notify you (e.g. telephonically, via fax) as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information (also described under Standard Claims above).

c. Review of Expedited Claim by an Independent Review Organization (IRO). Following the preliminary review that a request is eligible for expedited External Review, the Plan will assign an IRO (following the process described under Standard Review above). The Plan will expeditiously (e.g. meaning via telephone, fax, courier, overnight delivery, etc.) 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, (described above under Standard Claims). In reaching a decision, the assigned IRO must review the claim *de novo* (as if it is 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 its final expedited External Review decision, in accordance with the requirements set forth above under Standard Claims, as expeditiously as your medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited External Review. If the notice of the IRO's decision is not in writing, within forty-eight (48) hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

1. If the IRO's final External Review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.
2. 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).

All other terms and conditions of the Plan shall remain unchanged and in full force and effect.

Dated this 19th day of October, 2022.

Chairman

Co-Chairman