Amendment No. 4 to the
Local Union No. 9 IBEW and Outside Contractors
Active Employees Health and Welfare Plan
Plan Document and Summary Plan Description
(2021 Edition)

Grandfathered Health Plan Status

The Trustees believe that this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"), which permits our Plan to preserve certain basic health coverage already in effect before the law was passed. However, as with all grandfathered health plans, our Plan:

- May not include certain consumer protections of the Affordable Care Act that apply to other plans; and
- Must comply with certain other consumer protections in the Affordable Care Act (for example, the elimination of lifetime limits on benefits).

Contact the Fund Office if you have questions about what it means for a health plan to have a grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 866-444-3272 or www.dol.gov/ebsa/healthreform. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

Amendment No. 4

In accordance with the amendment and termination provision of the Local Union No. 9, IBEW and Outside Contractors Health & Welfare Fund Summary Plan Description/Plan Document Benefits and Eligibility Rules, Effective July 1, 2022 ("Plan"), as stated on page 76 of the Plan, the Fund has adopted the following changes.

1. Effective January 1, 2022, the first bullet in the subsection entitled Required Pre-Authorization, on page 17 of the Plan, is restated in its entirety as follows:
   a. Inpatient hospitalizations, excluding routine deliveries and hospitalizations for Emergency Services.
2. Effective January 1, 2022, a new subsection is added after the subsection entitled EXPENSES NOT COVERED UNDER MEDICAL BENEFITS subsection, on page 23 of the Plan. The new subsection reads as follows:

NO SURPRISES ACT REQUIREMENTS

a. Air Ambulance Services

Air Ambulance Services are medical transport for Patients by a rotary wing air ambulance, as defined in 42 CFR § 414.605, or fixed wing air ambulance, as defined in 42 CFR § 414.605. The No Surprises Act requires Air Ambulance Services, to the extent covered by the Plan, to be covered as follows:

- Air Ambulance services from a non-PPO Provider will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the services had been furnished by a PPO Provider;
- The cost-sharing amount will be calculated as if the total amount that would have been charged for the services by a PPO Provider of Air Ambulance Services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services;
- Any cost-sharing payments the Participant or Dependent makes with respect to covered Air Ambulance services will count toward your in-network deductible and in-network Out-of-Pocket maximum in the same manner as those received from a PPO Provider; and
- In general, a Participant or Dependent cannot be balance billed for these Air Ambulance Services.

b. Continuing Care Patients

If a Participant or Dependent is a Continuing Care Patient and the Plan terminates its contract with a PPO Provider or a PPO Facility or Hospital, or benefits are terminated because of a change in terms of Providers' and/or Facilities' participation in the Plan, the Plan will do the following:

1. Provide notice of the Plan's termination of its contracts with the PPO Provider or Facility and inform the Patient or their representative of the Patient's right to elect continued transitional care from the provider or facility; and
2. Allow the Patient (90) days of continued coverage at the in-network cost sharing to allow for a transition of care to a PPO Provider or Facility.

c. Emergency Services

The No Surprises Act requires Emergency Services to be covered as follows:

- Without the need for any prior authorization determination, even if the services are provided on an out-of-network ("Non-PPO") basis;
- Without regard to whether the health care provider furnishing the Emergency Services is a PPO Provider or a PPO Facility, as applicable, with respect to the services;
- Without imposing any administrative requirement or limitation on non-PPO Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from PPO Providers and PPO Facilities;
- Without imposing cost-sharing requirements on Non-PPO Emergency Services that are greater than the requirements that would apply if the services were provided by a PPO Provider or a PPO Facility;
- By calculating the cost-sharing requirement for Non-PPO Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services;

- By counting cost-sharing payments you make with respect to non-PPO Emergency Services toward your PPO Provider deductible and PPO Provider Out-of-Pocket maximum in the same manner as those received from a PPO Provider; and
- In general, Participants and Beneficiaries cannot be balance billed for these Emergency Services.

d. Non-Emergency Services

The No Surprises Act requires non-emergency services performed by non-PPO Provider at a PPO Health Care Facility to be covered as follows:

- With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a PPO Provider;
- By calculating the cost-sharing requirements as if the total amount that would have been charged for the items and services by such PPO Provider were equal to the recognized amount for the items and services; and
- By counting any cost-sharing payments made toward any PPO Provider deductible and PPO Provider Out-of-Pocket maximums applied under the Plan (and the PPO Provider deductible and Out-of-Pocket maximums must be applied) in the same manner as if such cost-sharing payments were made with respect to items and services furnished by a PPO Provider.
- In general, Participant and Beneficiaries cannot be balance billed for these items or services.

Notice and Consent Exception

Non-emergency items or services provided or performed by a non-PPO Provider at a PPO Facility will be covered based on Plan's non-PPO provider benefits and forgo the financial protections of the No Surprises Act if:

- At least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), the Patient (or their representative) is provided with a written notice, as required by federal law, that the provider is a Non-PPO Provider with respect to the Plan, the estimated charges for your treatment and any advance limitations that the Plan may put on treatment, the names of any PPO Providers at the facility who are able to provide treatment, and that the Patient may elect to be referred to one of the PPO Providers listed; and
- The Patient gives written informed consent to continued treatment by the non-PPO Provider, acknowledging that the Patient understands that continued treatment by the out-of-network provider may result in greater expenses.
- The notice and consent exception does not apply to Ancillary Services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the non-PPO Provider satisfied the notice and consent criteria and, therefore, these services will be covered as follows:
  - With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a PPO Provider;

- With cost-sharing requirements calculated as if the total amount charged for the items and services were equal to the Recognized Amount for the items and services; and
- By counting any PPO Provider deductible and PPO Provider Out-of-Pocket maximums, as if such cost-sharing payments were with respect to items and services furnished by a PPO Provider.
- In general, Participants and Beneficiaries cannot be balance billed for these items or services.

e. Provider Directory

The Provider Directory will be updated at least every ninety (90) days. If a Participant or Dependent is informed by the Plan through a telephone, electronic, or internet-based inquiry, or receives information from a print or electronic Provider Directory that a provider is a PPO Provider, but, in fact, the provider is a non-PPO Provider and services are furnished by that non-PPO Provider, the Plan will:

1. Apply a cost-sharing amount that is no greater than the cost-sharing amount that would have been assessed if the provider was a PPO Provider; and
2. Apply the Out-of-Pocket limit, if any, as if the services were provided by a PPO Provider.

3. Effective January 1, 2022, a new subsection is added after Post-Service Claims, on page 50 of Plan. The subsection reads as follows:

NO SURPRISES ACT SERVICES CLAIMS

The non-PPO Provider will receive an initial payment or denial of payment from the Plan for No Surprise Act Services within 30 days receipt of all information necessary to adjudicate the claim.

If a claim is subject to the No Surprises Act, the Participant or Dependent cannot be required to pay more than the cost-sharing amount under the PPO Plan and the provider or facility is prohibited from billing the Participant or Dependent in excess of the required cost-sharing amount.

4. Effective January 1, 2022, a new subsection is added after the subsection entitled AUTHORIZED REPRESENTATIVE on page 57 of the Plan, and before the subsection entitled COORDINATION OF BENEFITS, on page 58 of the Plan. The new subsection reads as follows:

EXTERNAL REVIEW OF CLAIMS

If your initial claim for health care benefits has been denied (i.e., an adverse benefit determination) in whole or in part, and you are dissatisfied with the outcome of the Plan's internal claims and appeals process described earlier, you may (under certain circumstances) be able to seek external review of your claim by an Independent Review Organization ("IRO"). This process provides an independent and unbiased review of eligible claims in compliance with the Affordable Care Act.

Claims Eligible For The External Review Process

Post-Service, Pre-Service, Urgent Care, and Concurrent Care Claims, in any dollar amount, are eligible for external review by an IRO if:

a. The denial involves surprise billing or cost-sharing issues that are protected under the No Surprises Act for Emergency Services, Air Ambulance Services, and non-emergency services provided by a Non-PPO Provider at a PPO Health Care Facility.

   A denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or dependent fails to meet the requirements for eligibility under the plan is not eligible for external review.

   In general, you may only seek external review after you receive a "final" adverse benefit determination under the Plan's internal appeals process. A "final" adverse benefit determination means the Plan has continued to deny your initial claim in whole or part and you have exhausted the Plan's internal claims and appeals process.

   Under limited circumstances, you may be able to seek external review before the internal claims and appeals process has been completed:

   - If the Plan waives the requirement that you complete its internal claims and appeals process first.
   - In an urgent care situation (see "Expedited External Review Of An Urgent Care Claim"). Generally, an urgent care situation is one in which your health may be in serious jeopardy or, in the opinion of your health care professional, you may experience pain that cannot be adequately controlled while you wait for a decision on your internal appeal.
   - If the Plan has not followed its own internal claims and appeals process and the failure was more than a minor error. In this situation, the internal claims and appeal is "deemed exhausted," and you may proceed to external review. If you think that this situation exists, and the Plan disagrees, you may request that the Plan explain in writing why you are not entitled to seek external review at this time.

External Review of a Standard (Non-Urgent Care) Claim

Your request for external review of a standard (not Urgent Care) claim must made in writing within four (4) months after you receive notice of an adverse benefit determination.

Because the Plan's internal claims and appeals process generally must be exhausted before external review is available, external review of standard claims will ordinarily only be available after you receive a "final" adverse benefit determination following the exhaustion of the Plan's internal claims and appeals process.

To begin the standard external review process, send a written request for an external review to:

Rita Becker
Local No. 9 IBEW and Outside Contractors Active Employees
Health and Welfare Fund
18670 Graphics Drive, Suite 201
Tinley Park, IL 60477
708-449-9004
rita.becker@benesys.com

Preliminary Review of a Standard (Non-Urgent Care) Claim by the Plan

Within five (5) business days of the Plan's receipt of your request for external review of a standard claim, the Plan will complete a preliminary review of the request to determine whether:

- 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, you were covered at the time the health care item or service was provided;
- The adverse benefit determination satisfies the above-stated requirements for a claim eligible for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan; or to a denial that is based on a contractual or legal determination, or a failure to pay premiums causing a retroactive cancellation of coverage;
- You have exhausted the Plan's internal claims and appeals process (or a limited exception allows you to proceed to external review before that process is completed); and
- Your request is complete, meaning that you have provided all of the information or materials required to process an external review.

Within one (1) business day of completing its preliminary review, the Plan will notify you in writing whether:

- Your request is complete and eligible for external review;
- Your request is complete but not eligible for external review. (In this situation, the notice will explain why external review is not available, and provide contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).); or
- Your request is incomplete. (In this situation, the notice will describe the information or materials needed to make the request complete. You must provide the necessary information or materials within the four (4) month filing period, or, if later, within 48 hours after you receive notification that your request is not complete.)

Review of a Standard (Not Urgent Care) Claim by the IRO

If your request is complete and eligible for external review, the Plan will assign it to an accredited IRO. The Plan has arranged for at least three (3) accredited IROs to provide external review of claims, and it rotates assignments among these IROs. In addition, the IRO may not be

eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

Once the claim has been assigned to an IRO, the following procedures apply:

- The IRO will timely notify you in writing that your request is accepted for external review.
- The IRO will explain how you may submit additional information regarding your claim if you wish. In general, you must provide additional information within ten (10) business days. The IRO is not required to, but may, accept and consider additional information you submit after the ten (10)-business day deadline; and
- Within five (5) business days after the claim has been assigned to the IRO, the Plan will provide the IRO with the documents and information it considered in making its adverse benefit determination.
- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo, meaning that the IRO is not bound by the Plan's previous internal claims and appeal decisions. However, the IRO must review the Plan's terms to ensure that its decision is not contrary to the terms of the Plan, unless those terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.
- To the extent additional information or materials are available and appropriate, the assigned IRO may consider the 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).
- In a standard case, the IRO will provide written notice of its final decision to you and the Plan within 45 days after the IRO receives the request for the external review.

The IRO's decision notice will contain:

- A general description of the reason(s) 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;
- The date that the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence or documents, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards relied upon;
- A statement that the IRO's decision is binding on you and the Plan, except to the extent that other remedies may be available to you or the Plan under applicable state or federal law;

- A statement that judicial review may be available to you; and
- A statement regarding assistance that may be available to you from an applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act.

  Illinois Department of Insurance, Consumer Services Section
  122 S. Michigan Ave., 19th Floor
  Chicago, IL 60603

  https://insurance.illinois.gov/consumer/consumerMain.html (website)
  DOI.complaints@illinois.gov (email)

Expedited External Review of an Urgent Care Claim

- You may request an expedited external review in the following situations if:
- You receive an adverse benefit determination regarding your initial claim 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
- You receive a "final" adverse benefit determination after exhausting the Plan's internal appeals procedure that (i) involves a medical condition for which the timeframe for completion of an standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; or (ii) concerns an admission, availability of care, continued stay, or health care item or service for which you received Emergency Services, and you have not yet been discharged from a facility.

To begin the expedited external review process, send a written request for an external review to:

Rita Becker
Local No. 9 IBEW and Outside Contractors Active Employees
Health and Welfare Fund
18670 Graphics Drive, Suite 201
Tinley Park, IL 60477
708-449-9004
rita.becker@benesys.com

Preliminary Review of an Urgent Care Claim by the Plan

Immediately upon receipt of a 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 above for the standard claim external review process). The Plan will defer to your attending health care professional's determination that a claim constitutes "urgent care." The Plan will immediately notify you (e.g., telephonically, via fax) whether your request for review meets the requirements for expedited review, and if not, it will provide or seek the information described above for the standard claim external review process.

Review of an Urgent Care Claim by the IRO

Upon a determination that a request is complete and eligible for an expedited external review following the preliminary review, the Plan will assign an accredited IRO. The Plan has arranged for at least three (3) accredited IROs to provide external review of claims, and rotates assignments among those IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

The Plan will expeditiously provide or transmit to the IRO all necessary documents and information that it considered in making its internal adverse benefit determination.

The 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. In reaching a decision, the IRO must review the claim de novo meaning that it is not bound by any previous decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO decision must not be contrary to the terms of the plan, unless the terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above for the standard claim external review process, as expeditiously as your medical condition or circumstances require, but not more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If notice of the IRO decision is not provided to you in writing, the IRO must provide written confirmation of the decision to you and the Plan within forty-eight (48) hours after it is made.

What Happens After the IRO Decision is Made?

- If the IRO's final external review decision reverses the Plan's internal adverse benefit determination, upon the Plan's receipt 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 internal adverse benefit 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 to the extent permitted under ERISA section 502.

5. Effective January 1, 2022, the definition for Allowable Charge, on page 78 of the Plan, of the Section entitled Glossary of Terms, on page 78 of the Plan, is restated in its entirety as follows.

Allowable Charge means:

- With respect to a network provider, the Allowable Charge is the negotiated fee/rate set forth in the agreement with the participating network health and/or dental provider, facility, or organization and the Plan.

- With respect to an out-of-network provider, the Allowable Charge means the amount as determined by the Board of Trustees for a particular service or supply. The Plan will not pay any Allowable Charge for out-of-network services or supplies that is determined by any provider, facility, or other person or organization, other than the Board of Trustees.
- With respect to Emergency Services provided by non-PPO Providers, for Non-Emergency Services provided by a non-PPO Provider at a PPO Facility, and for Air Ambulance Services by a non-PPO Provider, the Allowable Charge is the Out of Network Rate, as defined below.

6. Effective January 1, 2022, the Section entitled Glossary of Terms, on page 78 of the Plan, is amended to add Ancillary Services after the Ambulatory Surgical Facility or Ambulatory Surgical Treatment Center definition, on page 78 of the Plan. The Ancillary Services definition reads as follows:

   Ancillary Services

   Subject to rulemaking by the Secretary of the U.S. Department of Health and Human Services and with respect to services furnished by a Non-PPO Provider at a PPO Facility, the term "Ancillary Services" means the following:

   a. Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner,

   b. Items and services provided by assistant surgeons, hospitalists, and intensivists;

   c. Diagnostic services, including radiology and laboratory services;

   d. Item and services provided by other specialty practitioners, as specified through rulemaking by the federal government; and

   e. 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.

7. Effective January 1, 2022, the Section entitled Glossary of Terms, on page 78 of the Plan, is amended to add Continuing Care Patient after the Collective Bargaining Agreement definition, on page 78 of the Plan. The Continuing Care Patient definition reads as follows:

   Continuing Care Patient means an individual who is: (a) receiving a course of treatment for a Serious and Complex Condition, (b) scheduled to undergo non-elective surgery (including any post-operative care); (c) pregnant and undergoing a course of treatment for the pregnancy; (d) determined to be terminally ill and receiving treatment for the illness; or (e) is undergoing a course of institutional or inpatient care from the provider or facility.

8. Effective January 1, 2022, the Section entitled Glossary of Terms, on page 78 of the Plan, is amended to add Emergency Medical condition after the Elective Surgical Procedure definition, on page 80 of the Plan. The definition for Emergency Medical condition reads as follows:

   Emergency Medical Condition means a medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe

pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy.

9. Effective January 1, 2022, the Section entitled Glossary of Terms, on page 78 of the Plan, is amended to add Emergency Services before the Employee or Eligible Employee definition, on page 81 of the Plan. The definition for Emergency Services reads as follows:

   Emergency Services means the following:

   - An appropriate medical screening examination 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 to evaluate such Emergency Medical Condition; and
   - Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).
   - Emergency Services furnished by a non-PPO Provider or at a Non-PPO Hospital (regardless of the department of the hospital in which such items or services are furnished) or an Independent Freestanding Emergency Department also include post stabilization services (i.e., items and services provided 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 attending emergency physician or treating provider determines that the Patient is able to travel using nonmedical transportation or nonemergency medical transportation; and
     - The Patient or their representative is supplied with a written notice, as required by federal law, that the provider is a non-PPO Provider with respect to the Plan, an estimate of the charges for treatment and any advance limitations that the Plan may put on the treatment, the names of any PPO Providers at the facility who are able to treat the Patient, and that the Patient may elect to be referred to one of the PPO Providers listed; and
     - The Patient or their representative gives informed written voluntary consent to continued treatment by the non-PPO Provider, acknowledging that the Patient understands that continued treatment by the non-PPO Provider may result in greater costs to the Patient.

10. Effective January 1, 2022, the Section entitled Glossary of Terms, on page 78 of the Plan, is amended to add Health Care Facility after the Hazardous Pursuit, Hobby, or Activity definition, on page 81 of the Plan. The definition of Health Care Facility reads as follows:

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

    a. A hospital (as defined in section 1861(e) of the Social Security Act);

    b. A hospital outpatient department;

c. A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and

d. An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

11. Effective January 1, 2022, the Section entitled Glossary of Terms, on page 78 of the Plan, is amended to add Independent Freestanding Emergency Department after the Injury definition, on page 82 of the Plan. The definition of Independent Freestanding Emergency Department reads as follows:

Independent Freestanding Emergency Department means a health-care facility (not limited to those described in the definition of health care facility) that is geographically separate and distinct from a hospital under applicable State law and provides Emergency Services.

12. Effective January 1, 2022, the Section entitled Glossary of Terms, on page 78 of the Plan, is amended to add No Surprises Act Services after the Medicare definition, on page 83 of the Plan. The definition of No Surprises Act Services reads as follows:

No Surprises Act Services. The No Surprises Act (Public Law 116-260, Division BB) was signed into law on December 27, 2020 as part of the Consolidated Appropriations Act of 2021. The term **"No Surprises Act Services"** means the following, to the extent covered under the Plan: (1) out-of-network Emergency Services, (2) out-of-network Air Ambulance Services; (3) non-emergency Ancillary Services for anesthesiology, pathology, radiology and diagnostics, when performed by a Non-PPO Provider at a PPO Facility; and (4) other out-of-network non-emergency services performed by Non-PPO Provider at a PPO Facility with respect to which the provider does not comply with written federal notice and consent requirements.

13. Effective January 1, 2022, the Section entitled Glossary of Terms, on page 78 of the Plan, is amended to add Out-of-Network-Rate after the Office Visit definition, on page 83 of the Plan. The definition of Out-of-Network-Rate reads as follows:

Out-of-Network Rate. With respect to 1) Emergency Services provided by a Non-PPO Provider, Facility, or Independent Freestanding Emergency Department, 2) non-emergency services furnished by a Non-PPO Provider at a PPO Facility, and 3) Air Ambulance Services by a Non-PPO Provider, the term "Out-of-Network Rate" means one of the following in order of priority:

- If the state has an All-Payer Model Agreement, the amount that the state approves under that system;
- Applicable state law;
- The amount parties negotiate; or
- The amount approved under the independent dispute resolution (IDR) process pursuant to the No Surprises Act when open negotiations fail.

14. Effective January 1, 2022, the Section entitled Glossary of Terms, on page 78 of the Plan, is amended to add Qualifying Payment Amount after the Qualifying Coronavirus Preventive Service definition, on page 84 of the Plan. The definition of Qualifying Payment Amount reads as follows:

Qualifying Payment Amount (QPA) means the amount calculated using the methodology described in 29 CFR § 2590.716-6(c), which is generally the median of the contracted rates of the plan or issuer for the item or service in the geographic region.

15. Effective January 1, 2022, the Section entitled Glossary of Terms, on page 78 of the Plan, is amended to add Recognized Amount before the Room and Board Charges definition, on page 85 of the Plan. The definition of Recognized Amount reads as follows:

    Recognized Amount means (in order of priority) one of the following:

    a. An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;

    b. An amount determined by a specified state law; or

    c. The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.

    For Air Ambulance Services furnished by Non-PPO Provider, the Recognized Amount is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.

16. Effective January 1, 2022, the Section entitled Glossary of Terms, on page 78 of the Plan, is amended to add Serious and Complex Condition after the Self-Payments definition, on page 85 of the Plan. The definition of Serious and Complex Condition reads as follows:

    Serious and Complex Condition means one of the following:

    a. In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

    b. In the case of a chronic illness or condition, a condition that is the following:

        (1) Life-threatening, degenerative, potentially disabling, or congenital; and

        (2) Requires specialized medical care over a prolonged period of time.

This Amendment Number 4 to the Local Union No. 9, IBEW and Outside Contractors Active Employees Health and Welfare Plan, Plan Document and Summary Plan Description (2021 Edition) was adopted by the Board of Trustees on March 23, 2022.

Employer Trustees	**Union Trustees**
Chairman	Secretary