SUMMARY OF MATERIAL MODIFICATION TO THE DISTRICT NO. 9, INTERNATIONAL ASSOCIATION OF MACHINISTS AND AEROSPACE WORKERS WELFARE PLAN

The following is a summary of changes to the **C-3, C-3-D, C-3-G, and C-3-T** Plans of the District No. 9, International Association of Machinists and Aerospace Workers Welfare Plan (the "Plan") that the Trustees of the District No. 9, International Association of Machinists and Aerospace Workers Welfare Plan have recently adopted. Please keep this notice with your copy of the Summary Plan Description ("SPD") for future reference.

This summary only provides information regarding the changes that have been made to the Plans and does not provide all of the information that may be relevant to a particular provision. For more information concerning the provisions addressed by this summary, you should consult your SPD booklet and previous summaries of material modification.

EFFECTIVE JANUARY 1, 2021

1. Section 8.F.8 of all the SPD was replaced with the following:

   Charges for care, treatment, or surgery on the teeth, gums or alveolar process, or dentures, appliances, or supplies used in such care or treatment, except the Plan will pay the hospital charges if the covered individual is admitted to a hospital while receiving such treatment and will pay dental charges arising out of an accidental injury as set forth above at Section 8E10 of this Booklet.

2. Section 8.G.1.b(2) is replaced with the following:

   (2) Co-Payment and Out-of-Pocket Amounts. There is a 20% co-payment, up to a $100.00 maximum per month, for each Specialty Drug. There is also a separate annual $2,500.00 maximum for all Specialty Drugs combined. This means that after you have paid $2,500 in co-payments for Specialty Drugs during a calendar year, for the rest of the calendar year the Plan will cover 100% of the allowable cost as established by the PBM. Please note, the amounts you pay for Specialty Drugs will not be included in determining whether you have reached the annual out-of-pocket maximum that applies to other Major Medical Benefits under the Plan.
   After you have received $500,000.00 in Specialty Drug benefits, the co-payment increases to 50% for all Specialty Drug benefits you receive beyond $500,000.00, and the monthly and annual out-of-pocket limits no longer apply.

   *The Plan includes all amounts incurred for Specialty Drugs in calculating the $500,000, regardless of where obtained or administered, except for Specialty Drugs administered at an in-patient facility.

GRANDFATHERED STATUS

Federal regulations require us to advise you that this group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at:

District No. 9, International Association of
Machinists and Aerospace Workers Welfare Plan
12365 St. Charles Rock Road
Bridgeton, Missouri 63044
(314) 739-6442

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

SUMMARY OF MATERIAL MODIFICATION TO THE
DISTRICT NO. 9, INTERNATIONAL ASSOCIATION OF MACHINISTS AND AEROSPACE WORKERS WELFARE PLAN

The following is a summary of changes to the C-3, C-3-D, C-3-G, and C-3-T Plans of the District No. 9, International Association of Machinists and Aerospace Workers Welfare Plan ("Plan") that the Trustees of the Plan adopted effective January 1, 2022. Please keep this notice with your copy of the Summary Plan Description ("SPD") for future reference.

This summary only provides information regarding the changes that have been made to the Plan and does not provide all of the information that may be relevant to a particular provision. For more information concerning the provisions addressed by this summary, you should consult your SPD booklet and previous summaries of material modification.

1. The second sentence of Section 1F is replaced with the following:

   This $75.00 will not count toward the annual deductible.

2. Section 1H is replaced with the following:

   H. Other Cost Saving Features of the Plan

   You may also be able to reduce the cost of your medical care by taking advantage of other cost saving features of the Plan. If you need long-term maintenance prescription drugs, you should use the mail-in drug program described in Section 8G1 of this Booklet. If you need certain Specialty Drugs, you should enroll in the SaveonSP program described in Section 8G1b2(c) of this Booklet. Also, please see Section 8D3 of this Booklet with reference to pre-admission testing and outpatient surgeries.

3. The following paragraph is added to the end of the definition of Experimental or Investigative in Section 2B:

   This Experimental or Investigative definition and its application by the Plan does not include participation in or the "Routine Patient Costs" for "Approved Clinical Trials," as defined above, for which coverage is required by the PPACA.

4. Section 8C is replaced with the following:

   In addition to saving money by using Network providers and by complying with the pre-certification and utilization review requirements, you may also be able to reduce the cost of your medical care by taking advantage of other cost saving features of the plan. If you need long-term maintenance prescription drugs, you should use the mail-in drug program described in Section 8G1 of this Booklet. If you need certain Specialty Drugs, you should enroll in the SaveonSP program described in Section 8G1b2(c) of this Booklet. Also, please see Section 8D3 of this Booklet with reference to pre-admission testing and outpatient surgeries.

5. The second sentence of Section 8D1d is replaced with the following:

   This $75.00 does not count toward the annual deductibles.

6. Section 8G1b2 is replaced with the following:

(2) Co-Payment and Out-of-Pocket Amounts. Specialty Drugs will be covered under the prescription drug benefit as follows:

(a) Except as set out in Section 8G1b2c, there is a 20% co-payment, up to a $100.00 maximum per month, for each Specialty Drug. There is also a separate annual $2,500.00 maximum for all Specialty Drugs combined. This means that after you have paid out-of-pocket $2,500.00 in co-payments for Specialty Drugs during a calendar year, for the rest of the calendar year the Plan will cover 100% of the allowable cost as established by the PBM. Please note, the amounts you pay for Specialty Drugs will not be included in determining whether you have reached the annual out-of-pocket maximum that applies to other Major Medical Benefits under the Plan.

(b) In applying out-of-pocket maximums in connection with Specialty Drugs, the Plan looks only at expenses that are Essential Health Benefits. For purposes of this provision, out-of-pocket expenses only include amounts actually paid by a Covered Individual as a deductible, co-pay, and co-insurance after application of any secondary insurance or third-party payment (including co-pay assistance). Coupons, co-pay assistance and other forms of financial assistance, and any other amounts not paid out of the participant's or dependent's "pocket" are not considered by or accounted for under the Plan as out-of-pocket expenses.

(c) The Plan has adopted an Essential Health Benefit benchmark that identifies which Specialty Drugs are Essential Health Benefits and which are not. This benchmark is administered by Save On SP, LLC (SaveonSP) If you are taking a medication that is on the list of Non-Essential Health Benefit Specialty Drugs, a copy of which is available through the Fund Office, your payment share will depend on (a) the medication you are prescribed and (b) your enrollment status in the SaveonSP program.

- Once you enroll in the SaveonSP program, your co-insurance will be $0.
- Until you enroll in the SaveonSP program, you will be responsible for a 30% co-insurance amount. This co-insurance amount will not count towards your deductible or out-of-pocket maximums.

When you enroll in the SaveonSP program, SaveonSP will work with you to make sure you are enrolled for the appropriate third-party assistance for timely processing of prescriptions. You will pay nothing if you have enrolled in SaveonSP.

** Coverage by the Plan and access to the SaveonSP assistance program require that the prescription be medically necessary and appropriate and that, where necessary, prior authorization has been provided.

7. Section 8G1b3 is deleted in its entirety.

8. Sections 13C and 13D are replaced in their entirety with the following:

C. Medical Benefits

1. Initial Decision

All medical benefits will be paid as soon as administratively possible. You will be notified of an initial decision within certain timeframes, which differ for the different types of claims as described in the following paragraphs:

a. Urgent Care Claim

A medical benefit claim is considered an urgent care claim if the application of the time periods for making a non-urgent care claim determination could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim.

If your medical benefit claim is an urgent care claim, you will be notified of the benefit determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, you will be notified as soon as possible, but not later than 24 hours after receipt of the urgent care claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by you. You will be afforded a reasonable amount of time, taking the circumstances into account, but not less than 48 hours, to provide the specified information.

You will be notified of the determination as soon as possible, but in no case later than 48 hours after the earlier of (1) receipt of the specified additional information, or (2) the end of the period afforded you to provide the specified additional information.

b. Concurrent Care Claim

If the Plan has approved a concurrent or ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse benefit determination. In such a case, you will be notified of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before reduction or termination of the benefit.

If you request an extension to a previously approved concurrent or ongoing course of treatment involving an urgent care claim beyond the approved period of time or number of treatments, your request shall be decided as soon as possible, taking into account the medical exigencies. You will be notified of the benefit determination within 24 hours after receipt of the claim, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

c. Request for Prior Authorization or Other Pre-Service Medical Benefit Claim

A medical benefit claim is considered a request for prior authorization or other pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the benefit in question.

In the case of a request for prior authorization of a medical benefit or other pre-service medical benefit claim, the Plan will notify you of the benefit determination within a

reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim. If, due to matters beyond the control of the Plan, the Plan needs additional time to process the claim, the time for notifying you of the benefit determination may be extended for up to 15 days, provided that within 15 days after the Plan receives the claim, the Plan notifies you of those special circumstances and when it expects to make its decision. However, if such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information, and you will be afforded at least 45 days from receipt of the notice to provide the specified information.

d. Post-Service Benefit Claim

A benefit claim is considered a post-service claim if it is a request for payment of services which you have already received.

In the case of a post-service benefit claim, the Plan will notify you of any adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Plan needs additional time to process the claim, the Plan may extend the time for notifying you of its benefit determination on a one-time basis for up to 15 days, provided that within 30 days after the Plan receives the claim, it notifies you of those special circumstances and the date by which it expects to make a decision. However, if such a decision is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days from receipt of the notice to provide the specified information.

e. Calculation of Time Periods

For purposes of these time periods relating to the Plan's initial benefit determination, the period of time during which an initial benefit determination is required to be made begins at the time a claim is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the request. If a period of time is extended due to your failure to submit all information necessary, the period for making the determination is "frozen" from the date the notification is sent to you until the date you respond to the request for additional information.

f. Manner and Content of Denial of Initial Benefit Claims

If the Plan makes an adverse benefit determination, it must provide to you, in writing or by electronic communication, a notice that includes:

i. the specific reason(s) for the adverse benefit determination, including the denial code and its corresponding meaning;

ii. reference to the specific Plan provision(s) on which the adverse benefit determination is based;

iii. information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount (if applicable). The diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning are also available upon request;

iv. a description of any additional information or material that you must provide in order to perfect the claim, and an explanation of why the additional material or information is necessary;

v. a description of the Plan's internal and external review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under a federal law called "ERISA" following any denial on review of the initial denial;

vi. if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, and that a copy of such rule, guideline, protocol or other similar criterion will be provided to you upon request and without charge;

vii. if the adverse benefit determination is based on the Medical Necessity standard, that the treatment is Experimental or Investigational, or a similar exclusion or limit, either: (i) an explanation of the scientific or clinical judgment applying the exclusion or limit to your medical circumstances; or (ii) a statement that such an explanation will be provided to you upon request and without charge;

viii. a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits;

ix. in the case of an adverse benefit determination concerning an urgent care claim, a description of the expedited review process applicable to such claim; and

x. contact information for any applicable office of health insurance consumer assistance or ombudsman established under Public Health Services Act Section 2793 to assist individuals with the internal claims and appeals and external review processes.

NOTE: With regard to an urgent care claim, the information described in this subsection may be provided to you orally within the permitted time frame, provided that a written or electronic notification in accordance with this subsection is furnished to you no later than 3 days after the oral notification.

2. Appeal

a. Filing an Appeal

If your claim is denied or you disagree with the amount of the benefit, you have the right to have the initial decision reviewed. You must follow the appeals procedure before you file a lawsuit under ERISA, the federal law governing employee benefits. The procedure for filing an appeal will be described in the EOB and is described below.

All requests for review of initially denied urgent care claims, concurrent care claims, and prior authorization or other pre-service claims (including all relevant information) must be submitted to the Fund Office. All requests for review of initially denied post-service claims (including all relevant information) must be submitted to the Board of Trustees at the following address:

Board of Trustees
District No. 9, I.A.M.A.W. Welfare Trust
12365 St. Charles Rock Road

Written appeals must be filed within 180 days from the date of the decision. If a claim is denied and an appeal is not requested within 180 days from the date you were notified of the denial of your claim, the denial of the claim will be final.

For urgent care claims, your appeal may be made orally by calling the Fund Office at (314) 739-6442.

When filing or appealing a claim, you may authorize a representative to act on your behalf. However, you must provide notification to the Fund Office authorizing this representative. A health care provider that has knowledge of your medical condition may act as your authorized representative for urgent care claims.

Your written appeal must explain the reasons you disagree with the decision on your claim and you may provide any supporting documents or additional comments related to this review. When filing an appeal, you may:

- Submit additional materials, including comments, statements or documents; and
- Request to review all relevant information (free of charge). A document, record or other information is considered relevant if it:
- Was relied upon by the Plan in making the decision;
- Was submitted, considered, or generated in the course of making the decision (regardless of whether it was relied upon); or
- Demonstrates compliance with the claims processing requirements.

b. <u>Review on Appeal</u>

The Plan will review your appeal in accordance with the following provisions:

i. The Plan will provide a review that does not afford deference to the adverse initial benefit determination and that is conducted by an appropriate named fiduciary of the Plan who did not make the adverse initial benefit determination that is the subject of the appeal, nor is a subordinate of the individual who made the adverse initial determination.

ii. If the denial was based on medical judgment, the appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse initial benefit determination. The professional engaged for purposes of a consultation in the preceding sentence shall be an individual who was neither an individual who was consulted in connection with the adverse initial benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

iii. If the denial was based on medical judgment, the Plan will identify to you, upon request, the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse initial benefit determination, without regard to whether the advice was relied upon in making the adverse initial benefit determination.

iv. In the case of a requested review of an adverse initial benefit determination of an urgent care claim, the review process shall meet the expedited deadlines

described below. Your request for such an expedited review may be submitted orally or in writing and all necessary information, including the Plan's determination on review, shall be transmitted between the Plan and you by telephone, facsimile or other available similarly expeditious method.

v. The Plan will afford you an opportunity to review and receive, without charge, all relevant documents, information and records relating to the claim for benefits and to submit issues and comments relating to the claim for benefits in writing to the Plan. All comments, documents, records and other information submitted by you relating to the claim will be considered regardless of whether the information was submitted or considered in the initial benefit determination.

c. Deadlines for Appeal Decisions

The Plan will give you its decision on appeal in accordance with the following provisions:

i. *Urgent Care Claims*. A determination will be made as soon as possible, but not later than 72 hours from receipt of your appeal. The decision on the appeal is final and not subject to further review under the Plan's internal claim review procedures.

ii. *Concurrent Care Claims*. A determination will be made before the termination of your benefit. The decision on the appeal is final and not subject to further review under the Plan's internal claim review procedures.

iii. *Pre-Service Claims*. A determination will be made within 15 calendar days from receipt of your appeal. The decision on the appeal is final and not subject to further review under the Plan's internal claim review procedures.

iv. *Post-Service Claims*. A determination will be made at the Board of Trustees' next regularly scheduled meeting if your appeal is received at least 30 days before that meeting. If your appeal is received within 30 days of the Board of Trustees' next regularly scheduled meeting, the determination will be made at the second regularly scheduled meeting following receipt of your appeal. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your appeal may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached. The decision of the Board of Trustees on the appeal is final and not subject to further review under the Plan's internal claim review procedures.

d. Calculation of Time Periods

For purposes of the time periods specified in this subsection, the period of time during which a benefit determination on appeal is required to be made begins at the time the level of an adverse initial benefit determination is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a benefit determination or review accompanies the request for appeal review. If a period of time

is extended due to your failure to submit all information necessary, the period for making the determination shall be "frozen" from the date the notification requesting the additional information is sent to you until the date you respond to the request for additional information.

e. Manner and Content of Notice of Decision on Review

If the determination on appeal is adverse to you, you will receive a notice containing the following information:

i. the specific reason(s) for the adverse benefit determination, including the denial code and its corresponding meaning;

ii. reference to the specific Plan provision(s) on which the adverse benefit determination is based;

iii. information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount (if applicable). The diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning are also available upon request;

iv. a description of the Plan's external review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under a federal law called "ERISA";

v. if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, and that a copy of such rule, guideline, protocol or other similar criterion will be provided to you upon request and without charge;

vi. if the adverse benefit determination is based on the Medical Necessity standard, that the treatment is Experimental or Investigational, or a similar exclusion or limit, either: (i) an explanation of the scientific or clinical judgment applying the exclusion or limit to your medical circumstances; or (ii) a statement that such an explanation will be provided to you upon request and without charge;

vii. a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits;

viii. contact information for any applicable office of health insurance consumer assistance or ombudsman established under Public Health Services Act Section 2793 to assist individuals with the internal claims and appeals and external review processes; and

ix. the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and, if your benefit is an insured benefit, your State insurance regulatory agency."

f. Prescription Drug Claims and Appeals

Prescription Drug benefit claims and appeals will be processed generally in accordance with the same procedures that apply to medical benefit claims under Sections 13C1 and 13C2, above, except that the PBM will make the initial determination and will resolve appeals regarding prescription drug benefits. The PBM has procedures for reviewing appeals of denied prescription drug claims that are generally consistent with the procedures described in Section 13C2 above. In the event your claim for a prescription drug benefit is denied, the PBM will advise you of its appeal procedures.

3. External Review Procedure

a. Deadline for External Review

If you receive notice of an adverse benefit determination or final adverse internal appeal determination involving medical judgment or a rescission of coverage, you may file a request for an external review within 4 months after the date you receive notice of the adverse benefit determination or final adverse internal appeal determination.

Your request for an external review should be sent to the Fund Office unless you are specifically instructed otherwise in the appeal determination notice that is sent to you. If there is no corresponding date 4 months after the date of receipt of the notice, then the request must be filed by the first day of the fifth month following your receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date falls on a Saturday, Sunday, or Federal holiday, the filing deadline is extended to the next day that is not a Saturday, Sunday or Federal holiday.

b. Preliminary Review

Within 5 business days following receipt of your request for an external review, the Plan will complete a preliminary review of the request to determine whether:

i. you are covered or were covered under the Plan at the time the health care item, service or other benefit was requested;

ii. the adverse benefit determination or final adverse internal appeal determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan;

iii. you have exhausted the Plan's internal appeal process, unless you are not required to exhaust the internal appeal process under federal regulations; and

iv. you have has provided all of the information and forms required to process an external review.

c. Notice of Preliminary Review

Within one (1) business day after completion of the initial review, the Plan will issue to you a notice in writing regarding your eligibility for external review. If your request for external review is complete but not eligible for external review, the notice will include the reasons for your ineligibility and contact information for the Employee Benefits Security Administration (toll-free 866-444-3272). If your request for external review is not complete, the notice will describe the information or materials needed to make the request complete and you will be allowed to perfect your request for external review

within the 4-month filing period or within the 48-hour period following your receipt of the notice, whichever is later.

d. Review by Independent Review Organization

i. If your request for external review is eligible for submission to an Independent Review Organization (IRO), the Plan will assign your request for external review to an IRO to evaluate your eligibility for external review and will conduct the external review in accordance with procedures established under federal law. The IRO will be assigned in accordance with the Plan's rules, which provide an assignment or rotation method that ensures independence and against a bias towards the Plan. The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits.

ii. Upon receipt of your request for external review, the IRO will timely notify you in writing of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within 10 business days following the date you receive this notice additional information that the IRO will consider when conducting the external review. The IRO may, but is not required to, accept and consider additional information submitted after 10 business days.

iii. Within 5 business days after the date of assignment to the IRO, the Plan will provide to the IRO any documents and any information considered in making the adverse benefit determination or final adverse internal appeal determination. Failure by the Plan to provide documents cannot delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or the final adverse internal appeal determination. Within one (1) business day after making the decision, the IRO will notify you and the Plan.

iv. Upon receipt of any information submitted by you in accordance with subsection c above, within one (1) business day the assigned IRO will forward that information to the Plan. Upon receipt of that information, the Plan may reconsider its adverse benefit determination or final adverse internal appeal determination that is the subject of the external review. Reconsideration by the Plan cannot delay the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final adverse internal appeal determination and provide coverage or payment. Within one (1) business day after making such a decision, the Plan will provide written notice of its decision to you and the assigned IRO. The assigned IRO will terminate the external review upon receipt of the notice from the Plan.

v. The IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

vi. The IRO will review all 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 must observe the terms

of the Plan to ensure that the IRO's 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 applicable standards for clinical review criteria, including Medical Necessity, appropriateness, health care setting, level of care and effectiveness of a covered benefit, unless the criteria are inconsistent with the terms of the Plan or with applicable law. In addition to the documents and information provided, the assigned IRO will consider the following, to the extent available and to the extent the IRO considers them appropriate, in reaching an external review decision:

a. your medical records;

b. the attending health care professional's recommendation;

c. reports from appropriate health care professionals and other documents submitted by the Plan, you, or your treating health care provider;

d. appropriate medical practice guidelines, including evidence-based standards; and

e. the opinion of the IRO's clinical reviewer or reviewers based on the documents and information provided and to the extent the clinical reviewer or reviewers consider those documents and information appropriate.

f. The IRO will provide written notice of the final external review decision to the claimant and the Plan within 45 days after the IRO receives the request for external review. The IRO's external review decision will contain:

(i) a general description of the reason for the request for external review, including, where applicable, information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

(ii) the date the IRO received the assignment to conduct the external review and the date of the IRO's decision;

(iii) references to the evidence or documentation, including the specific coverage provisions and evidence-based standards that were considered in reaching the IRO's decision;

(iv) a discussion of the principal reason or reasons for the IRO's decision, including the rationale for the decision and any evidence-based standards that were relied on in making the decision;

(v) a statement that the determination is binding except to the extent that other remedies may be available under state or Federal law, as applicable, to either the Plan or to you;

(vi) a statement that judicial review may be available to you; and

(vii) current contact information, including phone number, for any applicable office of health insurance consumer assistance or

ombudsman established under Public Health Services Act Section 2793 to assist individuals with the external review processes.

4. Expedited External Review

a. <u>Request for Expedited External Review</u>

The Plan will allow you to make a request for an expedited external review with the Plan at the time you receive:

i. an adverse benefit determination if the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal under the federal interim final regulations 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

ii. a final internal adverse benefit determination, if you have a medical condition where 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 if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services but has not been discharged from a health care provider's facility.

b. <u>Preliminary Review</u>

Upon receipt of the request for the expedited external review, the Plan will conduct the Preliminary Review described above as soon as possible, except that the Plan will complete that review as soon as possible without regard to the 5 business day time period. Upon its determination of the Preliminary Review, the Plan will send the notice described in subsection 3c above as soon as possible.

c. <u>Review by Independent Review Organization</u>

Upon a determination that the request meets the threshold requirements for external review following the preliminary review, the Plan will assign an IRO in accordance with subsection 3d.i above. The Plan will provide or transmit all documents and information considered in making the adverse benefit determination or final adverse internal appeal determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents under the procedures for standard review. In reaching a decision, the assigned IRO will 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 must observe the terms of the Plan to ensure that the IRO's 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 applicable standards for clinical review criteria, including Medical Necessity, appropriateness, health care setting, level of care and effectiveness

of a covered benefit, unless the criteria are inconsistent with the terms of the Plan or with applicable law.

d. <u>Notice of Final External Review Decision</u>

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth in subsection D.4.g above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice of the expedited external review decision is not in writing, then within 48 hours after the date the notice is provided the assigned IRO will provide written confirmation of the decision to the claimant and the Plan in accordance with subsection D.4.g above.

5. After External Review

Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final adverse internal appeal determination, the Plan will provide coverage or payment for the claim, including authorizing or paying benefits, as soon as possible in accordance with applicable law. The Plan reserves the right to pursue judicial review or other remedies available or that may become available to the Plan under applicable law. The Plan will provide benefits (including making payment on the claim) without delay pursuant to a final external review decision in your favor, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

If the final external review upholds the Plan's adverse benefit determination or final adverse internal appeal 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), subject to all limitations described in this Section 13.

The external review standards provide that an external review decision is binding on the Plan, as well as on the you, except to the extent other remedies are available under state or Federal law.

6. IRO Maintenance of External Review Records

After a final external review decision, the IRO will maintain records of all claims and notices associated with the external review process for a minimum of 6 years. An IRO will make such records available for examination by the claimant, the Plan, or state or Federal government oversight agency upon request, except where such disclosure would violate state or Federal privacy laws.

9. Section 14Q is deleted in its entirety.

Please contact the Plan Office at (314) 739-6442 if you have any questions.

SUMMARY OF MATERIAL MODIFICATION TO THE
DISTRICT NO. 9, INTERNATIONAL ASSOCIATION OF MACHINISTS AND AEROSPACE WORKERS WELFARE PLAN

The following is a summary of changes to the C-3, C-3-D, C-3-G, C-3-T, and D-9A Plans of the District No. 9, International Association of Machinists and Aerospace Workers Welfare Plan ("Plan") that the Trustees of the Plan adopted effective January 15, 2022. Please keep this notice with your copy of the Summary Plan Description ("SPD") for future reference.

This summary only provides information regarding the changes that have been made to the Plan and does not provide all of the information that may be relevant to a particular provision. For more information concerning the provisions addressed by this summary, you should consult your SPD booklet and previous summaries of material modification.

The following new item 10 is added to Section 8.G.1.a:

10. Coverage Of Over-The-Counter COVID Tests

    Effective January 15, 2022 and through the end of the COVID-19 Public Health Emergency as declared by the U.S. Department of Health and Human Services, Covered Individuals may obtain up to eight over-the-counter COVID tests per 30-day period. Tests may be obtained at any pharmacy participating in the retail network by showing your prescription drug card. Tests may also be obtained by contacting the mail-order program at the number provided on your prescription drug card.

    If you use a non-network pharmacy to obtain the covered tests, you must pay the full cost and submit a claim form for reimbursement to the pharmacy benefit manager at the address provided in Section 14.H. You will receive reimbursement for each individual covered test in an amount equal to the lesser of (i) the amount you paid for the test or (2) $12.00. In order to receive reimbursement, you must submit such documentation as required by the Trustees.

    COVID tests purchased for employment purposes are not covered under this benefit.

Please contact the Plan Office at (314) 739-6442 if you have any questions.

SUMMARY OF MATERIAL MODIFICATION TO THE
DISTRICT NO. 9, INTERNATIONAL ASSOCIATION OF MACHINISTS AND AEROSPACE WORKERS WELFARE PLAN

The following is a summary of changes to the C-3, C-3-D, C-3-G, and C-3-T Plans of the District No. 9, International Association of Machinists and Aerospace Workers Welfare Plan ("Plan") that the Trustees of the Plan adopted effective July 1, 2022. Please keep this notice with your copy of the Summary Plan Description ("SPD") for future reference.

This summary only provides information regarding the changes that have been made to the Plan and does not provide all of the information that may be relevant to a particular provision. For more information concerning the provisions addressed by this summary, you should consult your SPD booklet and previous summaries of material modification.

1. The second sentence of Section 1B is replaced with the following:

   You can find a directory of Network Providers on the website of the Managed Care Organization shown on your identification card and in Section 14H. The Network Provider Directory will be updated at least every ninety days. If you receive inaccurate information from the Directory (or in response to an inquiry to the Managed Care Organization or the Fund Office) indicating that a Provider is a Network Provider, services and supplies provided by that Non-Network Provider will be covered as if the provider was a Network Provider.

2. A new paragraph is added before the second to last paragraph of Section 1B as follows:

   Continuity of Coverage. If you are a Continuing Care Patient and your provider's status changes from Network to Non-Network, the Plan will notify you in a timely manner of your right to elect continued transitional care from the provider for a period of up to 90 days at Network cost-sharing levels.

3. The seventh paragraph of Section 1B is replaced with the following:

   Please note that benefits for Emergency Services provided at a Network facility by Non-Network Providers will be paid at the Network rate to the extent required by the No Surprises Act.

   With regard to non-Emergency Services or supplies that are otherwise covered by the Plan, if such services or supplies are provided by or performed by a Non-Network Provider at a Network facility, the services or supplies are covered by the Plan:

   - With a cost-sharing requirement that is not greater than the cost-sharing requirement that would apply if the services or supplies had been furnished by a Network Provider;

- By calculating the cost-sharing requirement as if the total amount that would have been charged for the services or supplies by a Network Provider were equal to the Recognized Amount for the services and supplies; and
- By counting cost-sharing payments you make with respect to Non-Network non-Emergency Services or supplies toward your Network deductible and Network out-of-pocket maximum.

Notice and Consent Exception: Non-Emergency Services or supplies performed by a Non-Network Provider at a Network facility will be covered based on your Non-Network coverage 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), you are given written notice by the provider, as required by federal law, stating (1) that the provider is a Non-Network Provider with respect to the Plan, (2) the estimated charges for your treatment and any advance limitations that the Plan may apply to your treatment, (3) the names of any Network Providers at the facility who are able to treat you, and (4) that you may elect to be referred to one of the Network Providers listed; and
- You give informed consent to continued treatment by the Non-Network Provider, acknowledging that you understand that such continued treatment may result in greater cost to you.

The notice and consent exception does not apply to Ancillary Services and services or supplies furnished as a result of unforeseen, urgent medical needs that may arise at the time an service or supply is furnished, regardless of whether the Non-Network Provider satisfied the notice and consent criteria.

4. The third sentence of Section 1C is revised to read as follows:

   The Plan will pay 90% of covered charges of Network Providers and 60% of covered charges of providers who are not in the Network, other than as required by the No Surprises Act. See Section1B for an explanation of when the No Surprises Act requires payment of Non-Network charges at the Network rate.

5. The last sentence of the definition of **Allowable Charge** in Section 2B is revised to read as follows:

   Other than as required by the No Surprises Act, the Plan will not pay any allowable charge for Non-Network services or supplies that is determined by any provider, facility, or organization other than the Board of Trustees.

6. The definition of **Emergency** in Section 2B is replaced with the following:

   Emergency Medical Condition: A medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of

sufficient severity (including severe pain) so that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate health attention to result in serious jeopardy to the health of the individual (or for a pregnant individual, the health of the unborn child), serious impairment to bodily functions or serious dysfunction of any bodily organ or part. The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as an Emergency Medical Condition.

7. Section 2B is further revised by the addition of the following definitions:

Ancillary Services – Ancillary services include:

1. Services and supplies related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-Physician practitioner;
2. Services and supplies provided by assistant surgeons, hospitalists and intensivists;
3. Diagnostic services, including radiology and laboratory services; and
4. Services and supplies provided by a Non-Network Provider if there is no Network Provider who can furnish such item or service at such facility.

Continuing Care Patient – An individual who, with respect to a provider or facility is:

1. Undergoing a course of treatment for a serious and complex condition from the provider or facility;
2. Undergoing a course of institutional or inpatient care from the provider or facility;
3. Scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such surgery;
4. Pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
5. Determined to be terminally ill (as determined under Section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

Emergency Services: With respect to an Emergency Medical Condition:

1. An appropriate medical screening examination that is within the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including Ancillary Services routinely available in the Emergency Department to evaluate the Emergency Medical Condition, along with additional medical examination and treatment to the extent they are within the capabilities of the staff and facilities available to the Hospital or Freestanding Emergency Department to stabilize the patient;
2. 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 required to stabilize the

patient (regardless of the department of the hospital in which such further examination or treatment is furnished); and

3. With respect to Non-Network Providers and facilities, post-stabilization services until the patient is determined by the provider or facility to be able to travel using nonmedical transportation to nonemergency medical transportation. At such time, the patient may give informed consent to continued treatment by the Non-Network Provider which treatment shall not be considered Emergency Services. Such consent must acknowledge that the patient understands that continued treatment by the Non-Network Provider may result in greater cost to the patient and may only be given after the patient is provided with a written notice, as required by federal law, stating (1) that the provider is a Non-Network Provider with respect to the Plan, (2) the estimated charges for treatment and any advance limitations that the Plan may apply to treatment, (3) the names of any Network Providers at the facility who are able to treat the patient, and (4) that the patient may elect to be referred to one of the Network Providers listed.

Independent Freestanding Emergency Department – A public or private facility, licensed and operated according to the law, which is geographically separate and distinct from a Hospital under applicable state law and provides Emergency Services.

Qualifying Payment Amount – The amount calculated using the methodology described in 29 CFR 2590.716-6(c) which is generally the contracted rates of the Plan for the service or supply in the geographic region, with certain exceptions.

Recognized Amount – For services or supplies furnished by a Non-Network Provider:

a. An amount determined by an applicable All-Payer Model Agreement;
b. If there is not applicable All-Payer Model Agreement, an amount determined by a specified state law; or
c. If there is no applicable All-Payer Model Agreement or specified state law, the lesser of the amount billed by the Provider or facility or the Qualifying Payment Amount.

For air ambulance services (if covered by the Plan), the lesser of the amount billed by the Provider or facility or the Qualifying Payment Amount.

8. A new sentence is added to the end of Section 8A4 as follows:

Note that in certain situations, which are described below in Section 8B, Non-Network services and supplies will be covered at the Network level in accordance with the No Surprises Act.

9. The second sentence of Section 8B is replaced with the following:

   You can find a directory of Network Providers on the website of the Managed Care Organization shown on your identification card and in Section 14H. The Network Provider Directory will be updated at least every ninety days. If you receive inaccurate information from the Directory (or in response to an inquiry to the Managed Care Organization or the Fund Office) indicating that a Provider is a Network Provider, services and supplies provided by that Non-Network Provider will be covered as if the provider was a Network Provider.

10. A new paragraph is added before the last paragraph of Section 8B as follows:

    Continuity of Coverage. If you are a Continuing Care Patient and your provider's status changes from Network to Non-Network, the Plan will notify you in a timely manner of your right to elect continued transitional care from the provider for a period of up to 90 days at Network cost-sharing levels.

11. The last paragraph of Section 8B is replaced with the following:

    Please note that benefits for Emergency Services provided at a Network facility by Non-Network Providers will be paid at the Network rate to the extent required by the No Surprises Act.

    With regard to non-Emergency Services or supplies that are otherwise covered by the Plan, if such services or supplies are provided by or performed by a Non-Network Provider at a Network facility, the services or supplies are covered by the Plan:

    - With a cost-sharing requirement that is not greater than the cost-sharing requirement that would apply if the services or supplies had been furnished by a Network Provider;
    - By calculating the cost-sharing requirement as if the total amount that would have been charged for the services or supplies by a Network Provider were equal to the Recognized Amount for the services and supplies; and
    - By counting cost-sharing payments you make with respect to Non-Network non-Emergency Services or supplies toward your Network deductible and Network out-of-pocket maximum.

    Notice and Consent Exception: Non-Emergency Services or supplies performed by a Non-Network Provider at a Network facility will be covered based on your Non-Network coverage 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), you are given written notice by the provider, as required by federal law, stating (1) that

the provider is a Non-Network Provider with respect to the Plan, (2) the estimated charges for your treatment and any advance limitations that the Plan may apply to your treatment, (3) the names of any Network Providers at the facility who are able to treat you, and (4) that you may elect to be referred to one of the Network Providers listed; and

- You give informed consent to continued treatment by the Non-Network Provider, acknowledging that you understand that such continued treatment may result in greater cost to you.

The notice and consent exception does not apply to Ancillary Services and services or supplies furnished as a result of unforeseen, urgent medical needs that may arise at the time an service or supply is furnished, regardless of whether the Non-Network Provider satisfied the notice and consent criteria.

12. The last sentence of the second paragraph of Section 8D2 is revised to read as follows:

    See Section 8B for description of the two levels of providers and for an explanation of when the No Surprises Act requires payment of Non-Network charges at the Network rate.

13. The following sentence is added to the end of Section 8D2:

    Note: the Plan's Out-of-Pocket Maximum amounts for Network and Non-Network Providers are separate and will not be combined, other than as required by the No Surprises Act, which counts payments made for Non-Network Emergency Services and Non-Emergency Services provided by a Non-Network Provider at a Network facility against your Network Out-of-Pocket Maximum.

14. The first sentence of Section 13C3a **Deadline for External Review** is replaced with the following:

    If you receive notice of an adverse benefit determination or final adverse internal appeal determination involving medical judgment, a rescission of coverage, or the Plan's compliance with the surprise billing and cost-sharing protections of the No Surprises Act with respect to Emergency Services, Non-Emergency Services provided by a Non-Network Provider at a Network facility, and/or air ambulance services (if covered by the Plan), you may file a request for an external review. The request for external review must be filed within four months after the date the claimant receives notice of the adverse benefit determination or final adverse internal appeal determination.

Please contact the Plan Office at (314) 739-6442 if you have any questions.

SUMMARY OF MATERIAL MODIFICATION TO THE
DISTRICT NO. 9, INTERNATIONAL ASSOCIATION OF MACHINISTS AND AEROSPACE WORKERS WELFARE PLAN

The following is a summary of changes to the C-3, C-3-D, C-3-G, C-3-T, and D-9A Plans of the District No. 9, International Association of Machinists and Aerospace Workers Welfare Plan ("Plan") that the Trustees of the Plan adopted effective July 1, 2021. Please keep this notice with your copy of the Summary Plan Description ("SPD") for future reference.

This summary only provides information regarding the changes that have been made to the Plan and does not provide all of the information that may be relevant to a particular provision. For more information concerning the provisions addressed by this summary, you should consult your SPD booklet and previous summaries of material modification.

In all above-referenced Plans, the first sentence in the first **Note** in Section 8.G.7c is revised to read as follows:

The maximum payment per visit shall be no more than the contracted rate between the medical network and the Licensed Practical Nurse or Registered Nurse providing the medical service.

Please contact the Plan Office at (314) 739-6442 if you have any questions.

SUMMARY OF MATERIAL MODIFICATION TO THE DISTRICT NO. 9, INTERNATIONAL ASSOCIATION OF MACHINISTS AND AEROSPACE WORKERS WELFARE PLAN

The following is a summary of changes to the C-3, C-3-D, C-3-G, C-3-T, and D-9A Plans of the District No. 9, International Association of Machinists and Aerospace Workers Welfare Plan ("Plan") that the Trustees of the Plan adopted effective August 1, 2022. Please keep this notice with your copy of the Summary Plan Description ("SPD") for future reference.

This summary only provides information regarding the changes that have been made to the Plan and does not provide all of the information that may be relevant to a particular provision. For more information concerning the provisions addressed by this summary, you should consult your SPD booklet and previous summaries of material modification.

In all above-referenced Plans, the chart at the beginning of Section 10.C shall be revised to read as follows:

Type of Service	Plan Pays In Network	Plan Pays Out of Network
Vision Examination (once each 12 months)	Full Cost	Up to $36.00
Lenses (once each 12 months)		
Single Vision	Full Cost	Up to $28.00
Lined Bifocal	Full Cost	Up to $45.00
Lined Trifocal	Full Cost	Up to $56.00
Lenticular	Full Cost	Up to $80.00
Progressive Multifocals	Full Cost	$0.00
Photochromic	Full Cost	$0.00
Anti-Reflective Coating	Full Cost	$0.00
Polycarbonate	Full Cost	$0.00
Scratch Resistant Coating	Full Cost	$0.00
High Index	Full Cost	$0.00
Frame (one each 24 months)	Full Cost up to $175.00	Up to $45.00
Contact Lenses (once each 12 months)	Up to $150.00 for Professional Fees and Contact Lenses	Up to $105.00 for Professional Fees and Contact Lenses
Medically Necessary Contacts (usually required after cataract surgery)	Full Cost *Requires prior approval from vision administrator	Up to $210.00

Please contact the Plan Office at (314) 739-6442 if you have any questions.

SUMMARY OF MATERIAL MODIFICATION TO THE
DISTRICT NO. 9, INTERNATIONAL ASSOCIATION OF MACHINISTS AND AEROSPACE WORKERS WELFARE PLAN

The following is a summary of changes to the C-3, C-3-D, C-3-G, C-3-T, and D-9A Plans of the District No. 9, International Association of Machinists and Aerospace Workers Welfare Plan ("Plan") that the Trustees of the Plan adopted effective November 18, 2021. Please keep this notice with your copy of the Summary Plan Description ("SPD") for future reference.

This summary only provides information regarding the changes that have been made to the Plan and does not provide all of the information that may be relevant to a particular provision. For more information concerning the provisions addressed by this summary, you should consult your SPD booklet and previous summaries of material modification.

The last row of the chart in Section 8.G.5.c is revised to read as follows:

Benefit Limit	Per procedure limit starts 5 days prior to the transplant and ends on the date of discharge for the transplant hospitalization. The benefit limit applies to Phase 3 and Phase 4 transplant charges, including the transplant procedure and post-transplant care. Pharmacy costs are not included in the transplant limit.	Not Covered

Please contact the Plan Office at (314) 739-6442 if you have any questions.

SUMMARY OF MATERIAL MODIFICATION TO THE
DISTRICT NO. 9, INTERNATIONAL ASSOCIATION OF MACHINISTS AND AEROSPACE WORKERS WELFARE PLAN

The following is a summary of changes to the C-3, C-3-D, C-3-G, C-3-T, C-3GW and D-9A Plans of the District No. 9, International Association of Machinists and Aerospace Workers Welfare Plan ("Plan") which were recently adopted by the Trustees of the Plan. Please keep this notice with your copy of the Summary Plan Description ("SPD") for future reference.

This summary only provides information regarding the changes that have been made to the Plan and does not provide all of the information that may be relevant to a particular provision. For more information concerning the provisions addressed by this summary, you should consult your SPD booklet and previous summaries of material modification.

1. Effective May 12, 2023, the last sentence of Section 8.G.1.a(4) of the SPD is deleted without replacement.

2. Effective May 12, 2023, Section 8.G.1.a(10) of the SPD is deleted without replacement.

3. Effective September 1, 2023, the second sentence of Section 8.G.3 of the SPD is revised to read as follows:

   The usual deductible, copays and co-insurance apply if preventive services are provided by a Non-Network Provider.

4. Effective September 1, 2023, Section 8.G.17 of the SPD is deleted without replacement:

Please contact the Plan Office at (314) 739-6442 if you have any questions.