IMPORTANT NOTICE TO PLAN PARTICIPANTS

SUMMARY OF MATERIAL MODIFICATIONS TO THE SUMMARY PLAN DESCRIPTION FOR THE PAINTERS AND ALLIED TRADES DISTRICT COUNCIL 82 HEALTH CARE PLAN (Coverage B)

The Board of Trustees for the Painters and Allied Trades District Council 82 Health Care Plan Coverage B ("the Plan"), have made the following change to the Plan as further detailed below:

All Changes Effective July 1, 2023 (unless otherwise noted)

The Board of Trustees have made a number of changes to the Plan as further detailed below. ***Insert this notice into the Plan's Summary Plan Description which you recently received.***

Note: These changes will mean that the Plan is no longer considered a grandfathered health plan under the Affordable Care Act.

Annual Deductible

The Plan's Annual Deductible will be changed as follows:

Annual Deductible Effective July 1, 2023			**Previous Annual Deductible**		
	In-Network Providers	Out-of-Network Providers		In-Network Providers	Out-of-Network Providers
Individual	$250	$500	Individual	$300	$300
Family	$500	$1,000	Family	$900	$900

Annual Out-of-Pocket Maximum – Medical Benefits

The Plan has made the following changes to the Annual Out-of-Pocket Maximum as detailed in the table below.

Annual Out-of-Pocket Maximum Effective July 1, 2023			**Previous Annual Out-of-Pocket Maximum**		
	In-Network Providers	Out-of-Network Providers		In-Network Providers	Out-of-Network Providers
Individual Maximum	$2,250	$3,500	Individual Maximum	$1,000	$2,000

Family Maximum	$4,500	$7,000	Family Maximum	$3,000	$6,000

Additionally, the annual out-of-pocket maximum will include all member cost-sharing such as the Plan deductible, coinsurance and copayments. Previously it did not include the deductible.

Annual Out-of-Pocket Maximum – Prescription Drug Benefits

The Plan has added an Annual Out-of Maximum applicable to the Prescription Drug Benefit. This means that there is an annual maximum that you will have to pay for Prescription Drug Benefits.

Annual Out-of-Pocket Maximum – Prescription Drug Benefits	
Individual	$5,000
Family	$10,000

Previously, there was not a limit to how much a member would have to pay for prescription drugs on an annual basis.

Preventive Services

The Plan now provides for coverage of preventive services, in-network, at 100% as further provided below:

PREVENTIVE CARE SERVICES

In-Network	100%
Out-of-Network	80%

Further, the Plan will add Article XXVII-A to the Plan providing more detail regarding the coverage of preventive services.

ARTICLE XXVII-A

PREVENTIVE SERVICES

Section 1. General

The Plan will provide coverage of preventive health services as provided for in the Patient Protection and Affordable Care Act (PPACA) at 100% with no cost-sharing to the Participants when received at an in-network provider.

Preventive services received at an out-of-network provider remain subject to the Plan's cost-sharing provisions for those specific services.

Section 2. Benefit

Preventive services under PPACA consist of:

(a) Evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force (USPSTF);

(b) Immunizations for routine use for children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices for the Centers for Disease Control and Prevention;

(c) Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents; and

(d) Other evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women.

You can find the services currently considered as preventive services under the above noted categories at: https://www.healthcare.gov/coverage/preventive-care-benefits.

Previously, preventive services were covered at 80% in-network.

Prescription Drug Benefits – Copayment Schedule

The Plan has amended the Prescription Drug Benefit co-payment schedule as follows:

Member Co-Payment	Retail Benefit[1]	Mail Order Benefit[2]
Generic Drugs: Co-Payment Amount	10% co-pay with a minimum of $5.00 and a maximum co-pay of $50.00	5% co-pay with a $5.00 minimum and a maximum co-pay of $50.00
Single Source Brand[3] Name Drugs: Co-payment Amount	10% co-pay with a minimum Co-pay of $15.00 and a maximum co-pay of $50.00	5% co-pay with a minimum of $15.00 and a maximum co-pay of $50.00
Multiple-Source Brand[3] Name Drugs: Co-payment Amount	10% co-pay with a minimum of $15.00, plus the difference between the generic substitute and brand name price	5% co-pay with a minimum of $15.00, plus the difference between the generic substitute and brand name price

1 Based upon a benefit of a 31-day supply.
2 Based upon a benefit of a 90-day supply.
3 Specialty drug changes depend upon whether the specialty drug in question is a single or multiple source brand drug.

Previously, there was a flat $5.00 copayment for generic drugs at Retail and under the Mail Order Benefit.

Additional level of external third-party appeal for certain denied claim appeals

The Plan is amended to add provisions regarding your right to an external review of an adverse appeal decision in circumstances involving medical judgment or a recission of coverage. The following provisions address the new level of appeal.

External Third-Party Review of an Adverse Appeal Decision

If the Board of Trustees denies your claim appeal, you may further elect to have the adverse appeal determination be reviewed by an External Third-Party Review.

Standard External Review for Non-Urgent Claim

You may file a request for an external review within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination.

Within five (5) business days following the date of receipt of the external review request, the Plan Administrator will complete a preliminary review of the request to determine whether:

(A) You are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;

(B) The adverse benefit determination or the final adverse benefit determination is not based on the fact that you were not eligible under the Plan;

(C) You have exhausted the Plan's internal appeal process (unless exhaustion is not required); and

(D) You have provided all the information and forms required to process an external review.

Within 1 business day after completion of the preliminary review, the Plan Administrator will notify you in writing regarding whether your claim is eligible for external review. To be eligible for external review, the adverse appeal decision must be based upon a medical judgment, or it must involve a rescission of coverage. If your request was not complete, the notice will describe information or materials needed to complete request. You will have until the end of the 4-month period you had to file a request for an external review or 48 hours (whichever is later) to complete your request. If your request is complete but not eligible for external review, the notice will include the reasons your request was ineligible and contact information for the Employee Benefits Security Administration.

If the request is complete and eligible for external review, the Plan Administrator will assign an accredited independent review organization (IRO) to conduct the external review.

(A) The IRO will utilize legal experts where appropriate to make coverage determinations under the Plan and will notify you in writing of the request's eligibility and acceptance for external review. You may submit additional information in writing to the IRO within 10 business days that the IRO must consider when conducting the external review.

(B) The Plan Administrator will provide documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO.

(C) The IRO will review all the information and documents timely received and is not bound by the Plan Administrator's prior determination. The IRO may consider the following in reaching a decision:

(i) Your medical records;

(ii) The attending health care professional's recommendation;

(iii) Reports from appropriate health care professionals and other documents submitted by the Plan Administrator, you, or your treating provider;

(iv) The terms of the Plan;

(v) Evidence-based practice guidelines;

(vi) Any applicable clinical review criteria developed and used by the Plan Administrator; and

(vii) The opinion of the IRO's clinical reviewer or reviewers after considering information noted above as appropriate.

(D) The IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision.

Expedited External Review

(A) You may request an expedited external review when you receive:

(i) An adverse benefit determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal under the 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 have not been discharged from a facility.

(B) Immediately upon receipt of the request for expedited external review, the Plan Administrator will determine whether the request meets the reviewability requirements noted above for standard external review and will notify you of its eligibility determination.

(C) When the Plan Administrator determines that your request is eligible for external review an IRO will be assigned. The Plan Administrator will provide all necessary documents and information considered in making the adverse benefit determination

or final internal adverse benefit determination to the IRO by any available expeditious method.

(D) The IRO must consider the information or documents provided and is not bound by the Plan Administrator's prior determination. The IRO will provide notice of the final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the IRO's notice is not in writing, the IRO must provide written confirmation of the decision within 48 hours to the claimant and the Plan.

Coverage of Covid-19 At-Home Tests Ends May 12, 2023

The Biden Administration has declared that the national emergency regarding Covid-19 ends on May 11, 2023. During the declared national emergency, the Plan has provided coverage for up to eight (8) Covid-19 At-Home Tests per individual per month. With the end of the national emergency, starting on May 12, 2023, the Plan will no longer cover the costs of Covid-19 At-Home tests.

Coverage of Covid-19 Related Claims as of May 12, 2023

The Biden Administration has declared that the national emergency regarding Covid-19 ends on May 11, 2023. During the declared national emergency, the Plan has provided coverage for Covid-19 related claims with no member cost sharing. With the end of the national emergency, starting on May 12, 2023, the Plan will cover Covid-19 related claims in the same manner as all other benefits. Note that Covid-19 vaccinations received from an in-network provider will continue to be covered with no member cost sharing under the Affordable Care Act (ACA) preventive coverage guidelines.

If you have any questions regarding this notice, please contact the plan administrator at Wilson-McShane Corporation, 3001 Metro Drive, Suite 500, Bloomington, MN 55425, 952-854-0795.