Five Rivers Carpenters District Council Health & Welfare Fund
C/O Eastern Iowa Fringe Benefit Funds, Inc.
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PLAN CHANGES EFFECTIVE JANUARY 1, 2023

September 2022

The Board of Trustees of the Five Rivers Carpenters District Council Health & Welfare Fund has received confirmation from the parties to the Collective Bargaining Agreement between contributing employers to the Five Rivers Carpenters District Council Health & Welfare Fund and the Local Unions 308, 1260 and 678 of the Carpenters and Joiners of America, that the following plan changes will be made effective January 1, 2023. The Trustees continue to monitor the plan and balance keeping the plan design competitive with the financial constraints the Fund faces from the increasing costs associated with the benefits provided. Below is a summary of the changes associated with the plan:

DEDUCTIBLES, COINSURANCE, AND OUT-OF-POCKET LIMITS

Effective January 1, 2023, the Wellmark plan design will be as follows:

	Current Plan Design		Plan Design Effective January 1, 2023	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Coinsurance	90%	80%	**80%**	**70%**
Deductible - Single	$200	$500	**$300**	**$900**
Deductible - Family	$400	$1,000	**$600**	**$1,800**
Out-of-Pocket Limit - Single	$500	$2,000	**$3,000**	**$9,000**
Out-of-Pocket Limit - Family	$1,000	$3,500	**$6,000**	**$18,000**

You should receive your new medical identification (ID) cards before January 1. Please be sure to share your new ID card with providers for dates of service on or after January 1.

To find Wellmark providers, use the provider finder at https://www.wellmark.com/member/find-provider. Utilize the information from your Wellmark ID Card to include in the provider finder or call 800-524-9242.

Currently, there is not an out-of-pocket limit associated with your drug card costs through SavRx. Effective January 1, 2023, the following out-of-pocket limits will apply to your prescription drug coverage:

	Current		Effective January 1, 2023	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Out-of-Pocket Limit - Single	No Limit	No Limit	**$6,100**	**No Limit**
Out-of-Pocket Limit - Family	No Limit	No Limit	**$12,200**	**No Limit**

The total out-of-pocket limit for both medical and prescription drug services combined will not exceed $9,100 for an individual and $18,200 for a family.

Your prescription drug coinsurance and copayment amounts will remain the same and there will continue to be a $0 deductible for prescription drug benefits. Any limitations or exceptions currently in place will also remain.

EXPANDED PREVENTIVE BENEFITS

In accordance with the Affordable Care Act (ACA), the Plan is significantly expanding its coverage for preventive care services. The plan covers preventive services and immunizations identified by United States Preventive Services Task Force (USPSTF) and Advisory Committee on Immunization Practices (ACIP) and the Centers for Disease Control (CDC).

The list of covered services and immunizations are subject to change as the USPSTF, ACIP, and CDC revises their guidance. All covered preventive services will be paid at 100% without cost sharing when using in-network providers. If you use out-of-network providers, regular coinsurance and cost sharing provisions will apply.

Note that common adult immunizations, including flu shots will be covered by the Plan.
A full list of covered services can be found at www.uspreventiveservicestaskforce.org.
A full list of covered immunizations can be found at www.cdc.gov/vaccines/acip/index.html.

CLINICAL TRIALS

The Plan will cover the patient costs for a covered person enrolled in an approved clinical trial. An "approved clinical trial" is defined as a Phase I, II, III or IV clinical trial for the prevention, detection or treatment of cancer or other life-threatening condition that is: (1) federally funded or approved; (2) conducted under an investigational new drug application reviewed by the Food and Drug Administration; or (3) a drug trial that is exempt from having such an investigational new drug application. A "life-threatening condition" is any disease from which the likelihood of death is probable unless the course of the disease is interrupted. "Routine patient costs" include all services and supplies that are typically covered by the Plan for persons not enrolled in clinical trials. Routine patient costs do NOT include: (1) the investigational item, device, or service itself; (2) services that are provided solely to satisfy data collection and analysis needs, or (3) services that are clearly inconsistent with the widely accepted and established standards of care.

NEW APPEALS PROCEDURES

If you appeal to the Board of Trustees but the review process still results in an adverse benefit determination (denial), you may, in certain cases, request an additional review by an independent review organization (IRO). An external review is available for claims denied based on clinical or scientific judgments, such as decisions based on medical necessity. It does not apply to claim denials related to a person's eligibility for coverage or specific Plan exclusions.

A request for an external appeal review must be filed with the Plan within four months of the date the claimant receives a notice that his/her internal appeal has been denied. If the deadline falls on a Saturday, Sunday, or federal holiday, the time limit will be extended to the next working day.

Within five business days following receipt of a request for an external appeal, the Fund will complete a preliminary review to determine whether the claim is eligible for an external appeal. Within one business day after completing the preliminary review, the Fund will send a notice to the claimant. That notice will contain ONE of these three responses:

- The notice will advise that the claim is eligible for an external appeal and the appeal will be processed as described below. OR:

- The notice will advise that the claim is eligible for an external appeal but some information or forms are missing. If anything required for an external appeal is missing, the notice will describe the information or materials needed to make the request complete and the Fund will allow the claimant to complete the request for an external appeal. This must be done within the four-month filing period described above, but the claimant will have no less than 48 hours from receipt of the notice. OR:

- If the claim is NOT eligible for an external appeal, the notice will advise the claimant of the reason(s) for that ineligibility and will give the claimant contact information for the Employee Benefits Security Administration of the Department of Labor (toll-free number 866-444-EBSA (3272)).

The Fund will assign an independent review organization (called an "IRO") to process the external appeal. The IRO must be accredited by URAC or a similar nationally recognized accrediting organization. External appeals will be assigned to an IRO on a rotating basis to ensure independence and impartiality. The assigned IRO will notify the claimant in writing that his/her external appeal will be processed. This notice will include a statement that the claimant may submit in writing to the assigned IRO, within ten business days of the date of receipt of the notice, additional information for the IRO to consider when conducting the external review. The IRO is permitted to, but is not required to, accept and consider additional information submitted after ten business days.

Within five business days after the claim has been assigned to an IRO, the Fund will provide to the assigned IRO the documents and any information considered in making the claim determination or the decision on the internal appeal. Failure by the Fund to timely provide such documents and information will not delay the processing of the external appeal.

Upon receipt of any information submitted by the claimant, the assigned IRO will, within one business day, forward that information to the Fund. Upon receipt of any such information, the Fund may reconsider its prior denial, although reconsideration by the Fund will not delay the processing of the external appeal. Within one business day after making such a decision, the

Fund will provide written notice of its decision to the claimant and to the assigned IRO. The assigned IRO will then terminate the external appeal.

The IRO will review all of the information and documents that were timely received. In reaching a decision, the IRO will not be bound by any decisions or conclusions reached during the Fund's internal appeals process. In reaching a decision, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the claimant's medical records, the recommendation of the attending health care professional, reports from other appropriate health care professionals, appropriate practice guidelines, applicable clinical review criteria and other documents submitted by the Fund. The IRO's decision will be consistent with the terms of the Fund's plan of benefits, unless those terms are inconsistent with applicable law.

The assigned IRO will provide written notice of the final external appeal decision within 45 days after the IRO receives the request for the external appeal. The IRO will deliver the notice of final external appeal decision to the claimant and the Fund. The IRO's written decision will be binding on both the claimant and the Fund, except to the extent that other remedies may be available under federal law. The IRO's decision will also advise that judicial review may be available to the claimant. If the IRO's decision reverses the Fund's benefit determination, the Fund will immediately provide coverage or payment of the claim.

An "expedited" external appeal is available if a claim has been denied and if:

- The claim was denied based on clinical or scientific judgments (see the first criterion for standard (non-expedited) external appeals for examples), and
- The denial of the claim involves a medical condition of the claimant for which the time required to complete an internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or
- The claimant filed an internal appeal, which was denied, and the time required to complete a standard (non-expedited) external appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function.

A claimant must request an expedited external appeal. The Fund will not evaluate the claimant's circumstances to see if he/she satisfies these criteria unless the claimant, in writing, specifically requests an expedited external appeal. Immediately upon receipt of such a request, the Fund will determine whether the request meets either of the criteria stated above, and will also evaluate if the claim meets the requirements of a standard (non-expedited) external appeal, except that the claimant need not have filed an internal appeal. The Fund will immediately evaluate the claimant's request and will provide the claimant a notice advising that:

- The claim is eligible for an expedited external appeal and the appeal will be processed as described below, OR
- The claim is eligible for an external appeal but some information or forms are missing. If anything required for an external appeal is missing, the notice will describe the information or materials needed to make the request complete, and the Fund will allow the claimant to complete the request for an external appeal. This must be done within the four-month filing period for an external appeal, but the claimant will have no less than 48 hours from receipt of the notice.

- If the claim is NOT eligible for an expedited external appeal, the notice will advise the claimant of the reason(s) for that ineligibility and will give the claimant contact information for the Employee Benefits Security Administration of the Department of Labor (toll-free number 866-444-EBSA (3272)).

Upon a determination that a claim is eligible for expedited external appeal, the Fund will immediately assign an IRO to process the appeal, following the general procedures applicable to a standard external review, except that the Fund will transmit all necessary documents and information regarding the claim to the assigned IRO, and will identify the appeal as an expedited appeal. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard external appeal. The IRO will notify the claimant and the Fund of the final external appeal decision 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 appeal. If the IRO's decision is not given in writing then, within 48 hours after the date of the oral notice of the decision, the IRO will provide written confirmation of the decision to the claimant and the Fund.

RETIREE PROGRAM

The Fund requires that if an Employee is eligible to participate in the Retiree Program, they must exercise their option when first eligible to do so. If they do not exercise their option to participate in the Retiree Program immediately upon retirement, they will not be allowed to begin participation at a later date.

You must provide the Fund Office with: (1) a copy of the Retirement letter you receive from the Carpenter's Pension Fund that states that you are retired; or (2) an Affidavit stating that you are retired. You may request the Affidavit from the Fund Office. Once the Fund Office receives notification of your retirement, you will be sent a Retiree Election Form if you qualify for the Retiree Plan.

The Retiree Election Form must be completed and returned to the Fund Office within sixty days. It is important to return this paperwork so your account can be set up appropriately. Questions regarding the Retiree Election Form should be directed to the Fund Office at Eastern Iowa Fringe Benefit Funds, Inc., 1831 16th Avenue SW, Cedar Rapids, IA 52404, at (319) 366-3623.