U.A. LOCAL 125 HEALTH AND WELFARE FUND
SUMMARY OF MATERIAL MODIFICATION

The Board of Trustees of the U.A. Local 125 Health and Welfare Fund (the "Fund") has amended and restated the terms of the Fund's Benefits Booklet. This is a Summary of Material Modifications ("SMM"), which provides a general description of the changes. This SMM is merely a summary for your convenience. Your benefits are determined in accordance with the amended and restated terms of the Fund's employee benefit plans, which are set forth in the Benefits Booklet. Contact Eastern Iowa Fringe Benefit Funds, Inc. (the "Fund Office") at (319) 362-7977 for answers to any questions you have regarding this SMM or for copies of the plans and all applicable amendments.

If you have a Benefits Booklet that is less than five years old, keep this SMM with the Booklet. Your Booklet, as modified by this SMM (and any other applicable SMMs) describes your benefits. The Fund automatically issues restated (updated) Benefits Booklets to existing participants every five years. If you would like a copy of the most recent restatement (the 2022 Edition of the Benefits Booklet), contact Eastern Iowa Fringe Benefit Funds, Inc.

Effective May 1, 2022, the 2021 Edition of the Benefits Booklet is replaced in its entirety with the 2022 Edition of the Benefits Booklet. The 2022 Edition of the Benefits Booklet supersedes all plan documents and summary plan descriptions that were previously issued with respect to any and all matters pending a final determination on or arising after May 1, 2022.

In restating the Benefits Booklet, the Trustees amended it, effective May 1, 2022, as follows:

- Aduhelm (Aducanumab) is a recently approved drug for the treatment of Alzheimers. There are serious questions as to whether Aduhelm is effective. Medicare has determined not to cover Aduhelm except in the case of clinical trials. Upon the advice of their benefits consultant, the Trustees determined that the Health Plan will exclude Aduhelm from coverage. The Trustees may review this decision in the future if consensus emerges that Aduhelm is effective.

- To retire and qualify for retiree coverage, you must file an affidavit of retirement with the Fund Office attesting that you have ceased working in any employment (or will cease working on a specified future date). You must use a form provided by the Fund Office. Contact the Fund Office for a copy of the form. Filing your affidavit with the Fund Office does not affect your status as active or retired with respect to other plans or entities, such as the national pension plan or the Union. If you do not work for an extended period and you do not file an affidavit of retirement, you may lose eligibility as an active journeyman. This could cause a loss of bank hours, HRA balance, and retiree

eligibility that you may otherwise have retained if you had timely filed an affidavit of retirement with the Fund Office. If you are considering retirement and you have questions about your options, contact the Fund Office.

- Text describing the Health Plan's rehabilitative benefits has been modified. Text has been deleted regarding rehabilitative care for conditions that have limited the initiation of normal speech and motor development. This text had no effect because such care would not be rehabilitative. The superfluous text was deleted to avoid confusion.

Effective September 1, 2022:

- For years, the Fund has terminated journeyman eligibility when a participant voluntarily stops working for contributing employers. That rule remains in effect. In addition, your eligibility for journeyman benefits will now be terminated if no employer contributions are made on your behalf for eighteen consecutive months. As a reminder, termination of eligibility under these circumstances results in the loss of all bank hours and any unused HRA balance.

The 2022 Edition of the Benefits Booklet also elaborates on certain existing provisions as follows:

- Healthcare providers, like other businesses, make errors in billing. Common errors include incorrect charges, duplicate charges, and duplicate invoices. Some out-of-network providers may intentionally bill in a manner designed to substantially inflate the cost of the services provided beyond the intrinsic value. They may also accidentally or fraudulently bill for services that were not provided. Read the explanations of benefits you receive from the Fund. If there are charges you do not understand, contact the provider for an explanation. If you identify errors, inflationary billing, or fraud, contact the Fund Office for assistance. It has long been the case that the Fund does not cover expenses for which you are not liable, which includes erroneous, inflated, or fraudulent charges. Language has been added to the Benefits Booklet to explicitly state that there is no coverage for invoiced charges that are erroneous, inflated, or fraudulent. For instance, if a healthcare provider bills you twice for one service, the Fund will provide coverage with respect to only one of the invoices. You must dispute the duplicative invoice with the healthcare provider.

- For purposes of claims and appeals to the Fund, you have the right to appoint a representative to act on your behalf. This allows a representative (e.g., a family member, or your attorney) to communicate with the Fund on your behalf. The Fund will treat the acts of your representative as if they are your acts. For instance, if your representative fails to timely appeal a denial of your claim, the result will be the same as if you had failed to timely appeal. To appoint a representative, you must file a written form with the Fund Office. Contact the Fund Office to obtain the appropriate form. For most claims, you may appoint any person or entity to represent you except the person or entity with which you incurred the expenses that are at issue in your Claim (e.g., your healthcare provider and your healthcare provider's company). If a dispute arises regarding coverage, your healthcare provider has a conflict of interest with you on the key issue of the extent of your liability to the provider. Your representative should exclusively represent your interests both with respect to the Fund's obligations to reimburse you and your obligation to pay your healthcare provider. Accordingly, to the maximum extent permitted by law, if you choose to appoint a representative, the Fund will not accept the appointment of your healthcare provider as your representative. Solely in the case of an appeal of an urgent care claim, as defined by 29 C.F.R. 2560.503-1(m)(1), you may appoint your healthcare professional (the person, not the professional's employer or company) as your representative.

- All healthcare benefits provided by the Fund are determined by reference to the "allowed amount". This is a dollar amount assigned to an item or service by a predetermined process that is used to calculate cost-sharing and reimbursement amounts. The purpose of this rule is to prevent the Fund from paying excessive amounts for out-of-network healthcare services that are provided without any opportunity to negotiate the cost. All health plans incorporate this rule in some way. Without it, out-of-network healthcare providers could charge you disproportionately large amounts for their services and the Fund would bear most of the cost. That would rapidly bankrupt the Fund. For years, the Fund has defined the allowed amount for out-of-network services to be 140% of the amount Medicare would pay. This Medicare reference pricing provides an objective process to determine out-of-network allowed amounts. Medicare reference pricing will almost always apply. If you receive an item or service that Medicare would cover in some fashion, Medicare reference pricing applies to all the charges associated with the item or service. Medicare reference pricing does not apply line item by line item. It applies based on the substance of the items and services provided. Where Medicare would not pay for some of the associated charges, the

allowed amount may be $0. Your provider may bill you in a way that differs substantially from the way Medicare would require the service to be billed. In such cases, the Fund will determine the allowed amount as if the provider had billed in the manner required by Medicare. In extremely rare cases where Medicare reference pricing cannot be applied in any rational manner, such as when you receive a newly developed item or service for which Medicare has yet to determine a price, one of two alternatives will be used to determine the allowed amount; the "Fair Health" database or 50% of the invoiced amount.