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Amendment No. 20 to the 2020 Summary Plan Description and Plan Document of the NECA-IBEW Welfare Trust Fund

WHEREAS, the Board of Trustees of the NECA-IBEW Welfare Trust Fund ("Fund") may, pursuant to the terms of the Summary Plan Description and Plan Document ("SPD"), amend the SPD.

NOW, THEREFORE, the Trustees amend the 2020 SPD as follows subject to the conditions specified above.

1. Effective September 14, 2026, the first bullet point of the definition of Allowable Charge under the Definitions Section of the SPD is revised to read as follows:

- With respect to a network Preferred Provider Organization (PPO) provider, the term "Allowable Charge" is the negotiated fee/rate set forth in the agreement, excluding clinical edits, with the participating network professional provider, facility, or organization and the Plan.

2. Effective September 14, 2026, the following definitions are added to the "Plan Definitions" Section of the SPD and such new definitions shall read as follows:

Billing Review. A review of billing documentation and related medical records undertaken to uncover any Invalid Charges, Clinical Edits and/or Excess Charges (as defined in this Document), as necessary and sufficient to allow the Board of Trustees on behalf of the Plan to reasonably assess the accuracy and validity of billed charges submitted in connection with a Claim and to make determinations as to whether any such charges exceed the Allowable Charge.

Clinical Edits. See ***Errors, Excess Charge(s), Invalid Charge(s), Medically Unlikely Edits (MUE), Unbundled Charges, Unbundling*** in Plan Definitions and in General Limitations and Exclusions.

Errors. Charges based on billing mistakes, improprieties, or illegitimate billing entries, including, but not limited to, up-coding, duplicate charges, charges for care, supplies, treatment, and/or services not actually rendered or performed, or charges otherwise determined to be invalid, impermissible, or improper based on any applicable law, regulation, rule, or professional standard. The Board of Trustees/Plan has the sole discretion to determine what constitutes an Error under the terms of this Plan.

Excess Charge(s). A charge or portion thereof billed for care and treatment of a Sickness, Illness or Injury that is not payable under the Plan because it exceeds the Allowable Charge or is determined by the Board of Trustees on behalf of the Plan to be based on Invalid Charges in accordance with the terms of this Plan Document. Also, charges for a service or supply furnished by a Direct Contract Provider in excess of the applicable negotiated rate.

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Invalid Charge(s). Charges (a) that are found to be based on Errors (as defined in this Document), Unbundles Charges, Unbundling, Misidentification, and/or Unclear Description; (b) charges for fees or services determined not to have been Medically Necessary or reasonable; (c) charges found by the Board of Trustees on behalf of the Plan to be in excess of the Allowable Charge, or (d) charges that are otherwise determined by the Board of Trustees on behalf of the Plan to be invalid or impermissible based on any applicable law, regulation, rule, or professional standard.

Medically Unlikely Edits (MUE). Charges related to incorrect coding based on UnitedHealthcare Reimbursement Policies, Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI), HCPCS/CPT code descriptions, CPT coding instructions, the nature of the service/procedure, and any other applicable coding guidelines or recommendations.

Unbundled Charges. Charges for medical equipment and supplies that are included in a facility charge; charges for, routine medical and/or surgical supplies that are included in the general cost of the procedure, nursing care and/or services that are performed within the scope of daily duties; surgery, procedure(s), and/or supplies that are included in a the surgical/procedure room rate; and C-codes that are packages and have no separate reimbursement surgery/procedures and supplies, and c-codes.

Unbundling. Charges for any items billed separately that are customarily included in a global billing procedure code in accordance with the American Medical Association's CPT® (Current Procedural Terminology) the Healthcare Common Procedure Coding System (HCPCS), and/or the National Correct Coding Initiative (NCCI) codes used by CMS. Charges include routine medical and/or surgical supplies that are included in the general cost of the procedure, nursing care and/or services that are performed within the scope of daily duties; surgery, procedures(s), and/or supplies that are included in a surgical procedure room rate; and C-codes that are packages and have no separate reimbursement surgery/procedures and supplies, and C-codes.

3. Effective September 14, 2026, the following new section entitled "Audit of Certain Charges" is added under the heading of the SPD entitled "OTHER PLAN FEATURES" and such new section shall read as follows:

Audit of Certain Charges

The Board of Trustees on Behalf of the Plan has the authority to refer any claim to its authorized designee for the purpose of performing a Billing Review. This review may be used to identify Errors, Invalid Charges, Excess Charges, Unbundled Charges, Medically Unlikely Edits (MUE), or any other matter that may impact claims adjudication.

In addition, revenue codes requiring CPT or HCPCS will be denied when the code is not present on a UB-04 or itemized bill.

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4. Effective September 14, 2026, the following new exclusions shall be added to the heading of the SPD entitled "General Limitations and Exclusions" and each new exclusion shall be assigned then next sequential number. Such new exclusions shall read as follows:

Error(s). Charges based on billing mistakes, improprieties, or illegitimate billing entries, including, but not limited to, up-coding, duplicate charges, charges for care, supplies, treatment, and/or services not actually rendered or performed, or charges otherwise determined to be invalid, impermissible, or improper based on any applicable law, regulation, rule, or professional standard.

Invalid Charge(s). Charges (a) that are found to be based on Errors (as defined in this Document), Unbundles Charges, Unbundling, Misidentification, and/or Unclear Description; (b) charges for fees or services determined not to have been Medically Necessary or reasonable; (c) charges found by the Board of Trustees on behalf of the Plan to be in excess of the Allowable Charge, or (d) charges that are otherwise determined by the Board of Trustees on behalf of the Plan to be invalid or impermissible based on UnitedHealthcare Reimbursement Policies, any applicable law, regulation, rule, or professional standard.

Excess Charges. A charge or portion thereof billed for care and treatment of a Sickness, Illness or Injury that is not payable under the Plan because it exceeds the Allowable Charge or is determined by the Board of Trustees on behalf of the Plan to be based on Invalid Charges in accordance with the terms of this Plan Document. Also, charges for a service or supply furnished by a Direct Contract Provider in excess of the applicable negotiated rate.

Unbundled Charges. Charges for medical equipment and supplies that are included in a facility charge; charges for routine medical and/or surgical supplies that are included in the general cost of the procedure, nursing care and/or services that are performed within the scope of daily duties; surgery, procedure(s), and/or supplies that are included in a surgical/procedure room rate; and C-codes that are packages and have no separate reimbursement surgery/procedures and supplies, and C-codes.

Medically Unlikely Edits (MUE). Charges related to incorrect coding based on Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI), HCPCS/CPT code descriptions, CPT coding instructions, the nature of the service/procedure, and any other applicable coding guidelines or recommendations.

5. Effective September 14, 2026, the following new section entitled "Additional Information" is added under the heading of the SPD entitled "CLAIMS AND APPEALS PROCEDURES" under the section "Medical Benefit Claims" under the subsection "Post-Service Claims" and such new section shall read as follows:

Additional Information

In certain instances, the Board of Trustees on behalf of the Plan or its designee, may require a provider to submit the following items for the Plan to adjudicate the claim:

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- A copy of the itemized bill;
- Medical records;
- Implant invoices;
- Any other information that may be useful to assist the Plan in adjudicating the claim.

6. Effective September 14, 2026, the following new section entitled "Billing Review" is added under the heading of the SPD entitled "CLAIMS AND APPEALS PROCEDURES" under the section "Medical Benefit Claims" under the subsection "Post-Service Claims" and such new section shall read as follows:

Billing Review

The Board of Trustees on behalf of the Plan has the authority to refer any claim to its authorized designee for the purpose of performing a Billing Review. This Billing Review may be used to identify Errors, Invalid Charges, Excess Charges, Unbundled Charges, Medically Unlikely Edits (MUE), Invalid Charges, or any other matter that may impact claims adjudication.

Specifically, the Board of Trustees on behalf of the Plan shall not, on a line-item basis (CPT, HRC, HCPCS, etc.) allow a greater reimbursement than billed charges. In addition, revenue codes requiring CPT or HCPCS will be denied when code is not present on UB-04 or itemized bill. The Board of Trustees on behalf of the Plan is entitled to rely on all other terms and conditions of this Plan Document, as well as all other nationally recognized billing and coding edits, e.g. the CMS's NCCI Correct Coding Initiative (CCI) edits and/or the Medically Unlikely Edits (MUE), when performing a Billing Review.

IN WITNESS WHEREOF, as authorized by the Board of Trustees, this Amendment No. 20 to the Fund's Summary Plan Description and Plan Document, 2020 Edition, is adopted on the __31st_____day of ____August_____, 2026.

DocuSigned by:
Billy Serbousek
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Chairman

DocuSigned by:
Steve Hughart
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Secretary