# SUMMARY OF MATERIAL MODIFICATIONS

Date: April 2023

To: Active and Retired Plan Participants and Their Eligible Dependents Enrolled in the Operating Engineers Local 139 Health Benefit Fund

From: The Board of Trustees

As the Trustees of the Operating Engineers Local 139 Health Benefit Fund (the "Fund"), we regularly review the Plan and make changes when necessary. By way of this Summary of Material Modification (SMM), we would like to make you aware of some significant Plan changes. Please read this SMM in its entirety to make sure you understand your health care coverage.

## ROUTINE ANNUAL PHYSICAL BENEFITS IMPROVED

Effective January 1, 2023, the Heath Dynamics program is no longer available to participants and spouses. Instead, the Fund will cover all in-network routine physical examinations at 100% for participants and spouses.

Routine physical examination includes: health history review, blood chemistry analysis, body composition, resting blood pressure, height and weight measurements, pulmonary function test, strength evaluation, flexibility testing, 12-lead EKG, cardiovascular fitness test, physician directed examination, urinalysis, colorectal cancer screening (does not include colonoscopy), chest x-ray or mammogram, pap smear and PSA test.

## PRESCRIPTION DRUG EXPENSES

Effective August 1, 2022, the Plan covers medications related to the treatment of attention deficit and attention deficit hyperactivity disorders regardless of age. The Plan previously required a prior authorization for individuals aged 19 or older for medical necessity review. As a reminder, all medications must be medically necessary.

## MATERNITY LOSS OF TIME BENEFIT

Effective January 1, 2022, the Plan's Loss of Time benefit is improved to increase the weekly benefit from $325 per week to $800 per week, up to 6 weeks from the date of delivery for a vaginal birth or up to 8 weeks from the date of delivery for a Cesarean birth, subject to tax withholding. The 7-day waiting period may apply.

## VOYA (RELIASTAR LIFE INSURANCE COMPANY)

Effective September 1, 2022, Voya (ReliaStar Life Insurance Company (ReliaStar Life)) replaced Metropolitan Life Insurance Company (Metlife) in providing coverage for Death, and Accidental Death and Dismemberment Benefits. Benefit levels and conditions were not changed.

## TRANSPLANT BENEFITS

Effective December 1, 2022, the Fund enhanced the Plan's transplant benefits to cover medically necessary experimental or investigative drug therapies for the treatment of antibody mediated rejection where two or more therapies have failed following organ transplants.

## IN-NETWORK INFERTILITY BENEFITS INCREASED

Effective June 1, 2022, the in-network infertility benefit has increased to $10,000 per person per lifetime for medical claims and $10,000 per person per lifetime for prescription drug benefits. For more information on infertility benefits, refer to the Summary Plan Description and Summary of Benefits.

## COMPLIANCE WITH THE NO SURPRISES ACT

Effective June 1, 2022, the Plan was amended to comply with the federal No Surprises Act. Out-of-network Protected Services, such as certain Emergency Services, and Continuing Care Services are covered by the Plan as if such services were furnished by an in-network provider. If you receive care provided in connection with a medical emergency at an Independent Freestanding Emergency Department that provides Emergency Services and is geographically distinct and licensed separately from a hospital, it will be covered as if the emergency department is a hospital as required by law.

Out of-network Protected Services and Continuing Care Services are subject to all other Plan limits and exclusions, including but not limited to deductibles, out-of-pocket maximums, Usual, Customary and Reasonable limitations, and Medical Necessity to the extent allowed by law. Your expenses for out-of-network Protected Services and Continuing Care Services will apply to satisfy your annual deductible.

### External Review of Claims Subject to the No Surprises Act

If you appeal a claim denial and the Trustees deny your appeal, you may elect to have the adverse appeal determination reviewed by an Independent Review Organization ("IRO") but only if your appeal involves Protected Services. If you elect to do so, you must file a written request for an external review of an adverse internal appeal decision with the Fund Office within four (4) months after the date of receipt of a notice of an adverse benefit determination on internal appeal. Contact the Fund Office for more information or to obtain the appropriate forms.

### New Definitions

*Continuing Care Patient* means an individual who, with respect to a provider or facility:

- Is undergoing a course of treatment for a serious and complex condition from the provider or facility, with "serious and complex condition" meaning (1) in the case of an acute Illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (2) in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time;
- Is undergoing a course of institutional or Inpatient care from the provider or facility;
- Is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- Is or was determined to be terminally ill and is receiving treatment for such Illness from such provider or facility.

*Continuing Care Services* means items and services provided in accordance with the following:

- In the case of an Eligible Person, and with respect to a provider or facility that has a contractual relationship with the Plan for furnishing items and services under the Plan (including a PPO provider or PPO facility), if, while such Eligible Person is a Continuing Care Patient with respect to such provider or facility: ( l) such contractual relationship is terminated; (2) benefits provided under the Plan with respect to such provider or facility are terminated because of a change in the terms of the participation of such provider or facility; or (3) a contract between the Plan and a health insurance issuer offering health insurance coverage in connection with the Plan is terminated, resulting in a loss of benefits provided under the Plan with respect to such provider or facility; the Plan will meet the following requirements with respect to such Eligible Person:
  - Notify each Eligible Person who is a Continuing Care Patient with respect to such a provider or facility of the termination and the individual's right to elect continued transitional care from such provider or facility;
  - Provide the Eligible Person with an opportunity to notify the Plan of the Eligible Person's need for transitional care; and
  - Permit the Eligible Person to elect to continue to have benefits provided under the Plan, under the same terms and conditions as would have applied, and with respect to such items and services as would have been covered under the Plan, had such termination not occurred, with respect to the course of treatment furnished by such provider or facility relating to such individual's status as a Continuing Care Patient during the period beginning on the date on which the Plan's notice of the termination is provided and ending on the earlier of the 90-day period, beginning on such date or the date on which such individual is no longer a Continuing Care Patient with respect to such provider or facility.

*Emergency Service* means, in general, certain medical services which are acutely needed to address severe pain or a life-threatening condition. Specifically, the term means, with respect to an emergency medical condition:

a. A medical screening examination (as required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an Independent Freestanding Emergency department) that is within the capability of the emergency department of a Hospital (as determined under the No Surprises Act) or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency medical condition; and

b. Within the capabilities of the staff and facilities available at the Hospital (as determined under the No Surprises Act) or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

c. Subject to the exception described in subsection d. below, if an Eligible Person is furnished the services in subsections a. or b. above with respect to an Emergency medical condition, the term Emergency Services will also include items and services that the Plan would cover if furnished by an in-network provider, which are furnished by an out-of-network provider (regardless of the department of the Hospital (as determined under the No Surprises Act) in which such items and services are furnished) after the Eligible Person is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the Emergency Services described in subsections

a. and b. above are furnished (for purposes of this definition, these items and services are "Post-Stabilization Services").

d. Post-Stabilization Services will not be considered Emergency Services if all of the following conditions are met:

- The attending emergency Physician or treating provider determines the Eligible Person is able to travel using nonmedical transportation or nonemergency medical transportation to an available PPO provider or PPO facility located within a reasonable travel distance, taking into account the individual's medical condition;
- The provider or facility furnishing such additional items and services satisfies the notice and consent criteria of Public Health Service Act section 2799B-2(d) and its implementing regulations with respect to such items and services;
- The Eligible Person (or a person authorized by law to provide consent on behalf of the Eligible Person) is in a condition to receive the information described in such notice and to provide informed consent; and
- The provider satisfies any additional requirements or prohibitions imposed under state law.

*Independent Freestanding Emergency Department* means a health care facility that provides Emergency Services and is geographically separate and distinct from a hospital, and separately licensed as such by a state, even if the facility is not licensed under the term "independent freestanding emergency department."

*Protected Services* means each of the following:

- Emergency Services furnished by an out-of-network provider;
- Air ambulance services furnished by an out-of-network provider, if the Plan provides or covers any benefits for air ambulance services; or
- Items and services (other than Emergency Services) furnished by an out-of-network provider with respect to a visit at an in-network hospital, hospital outpatient department, critical access hospital, or ambulatory surgical center, if such items and services would be covered by the Plan if furnished by an in-network provider (an "NSA-Covered Facility Claim"). For the purposes of such an NSA-Covered Facility Claim, a "visit" includes the furnishing of equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services, regardless of whether the out-of-network provider furnishing such items or services is physically at the facility. However, the term "Protected Services" will not include these items and services if the out-of-network provider satisfies the notice and consent criteria of Public Health Service Act section 2799B-2(d) and its implementing regulations with respect to such items and services, and the Eligible Person consents to receive the items or services from the out-of-network provider.

## TRANSSEXUAL/GENDER REASSIGNMENT CARE AND SERVICES EXCLUSION REMOVED

Effective June 1, 2022, this exclusion of coverage is removed from the Plan. Treatment for gender dysphoria is subject to general Plan limits and exclusions, including but not limited to in-network providers, deductibles, out-of-pocket maximums, and Medical Necessity.

## STATEMENT OF THE PLAN'S GRANDFATHERED STATUS

The Operating Engineers Local 139 Health Benefit Fund 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, such as 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, such as 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 (262) 549-9190 or (800) 242-7018.

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

## FINAL NOTE

Please share this SMM with your family members and store it with your Summary Plan Description (SPD)/Plan Document booklet for easy reference.

If you have any questions regarding this SMM or your Plan benefits, do not hesitate to contact the Fund Office at (262) 549-9190 or (800) 242-7018.

This Summary of Material Modifications provides only highlights of recent changes to the Operating Engineers Local 139 Health Benefit Fund. Full details are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify or terminate the Plan at any time.

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