AMENDMENT NUMBER THREE
TO THE OPERATING ENGINEERS LOCAL 139 HEALTH BENEFIT FUND
ECONOMY PLAN SUMMARY PLAN DESCRIPTION/PLAN DOCUMENT
2020 EDITION

The Operating Engineers Local 139 Health Benefit Fund has adopted the following change to the Economy Plan Summary Plan Description/Plan Document, 2020 Edition ("Plan"), effective November 11, 2021.

The subsection entitled "Beneficiary" under Accidental Death and Dismemberment (AD&D) Benefits beginning on page 44 will have the following paragraph added to the end of the section to read as follows:

In the event a married Employee designates his or her spouse as beneficiary and that marriage is legally terminated by divorce, then any prior beneficiary designation naming the former spouse as beneficiary shall be null and void. If the Employee desires to again designate the former spouse as beneficiary, the Employee must complete and submit a new beneficiary designation form after the marriage is terminated, listing such former spouse as beneficiary.

The Operating Engineers Local 139 Health Benefit Fund has adopted the following change to the Economy Plan, effective January 12, 2022.

The following subsection is added following the subsection entitled "COVID-19 Diagnostic Testing and Associated Provider Visits" on page 31, in the Section entitled "Covered Expenses":

Over-the-Counter COVID-19 Tests

During the National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak ("National Emergency"), and notwithstanding Plan language to the contrary, the Plan will reimburse costs incurred for over-the-counter ("OTC") COVID-19 tests, including tax and standard shipping costs. Such reimbursement is limited to eight (8) OTC tests per covered individual per calendar month. Requests for reimbursement shall be submitted on the COVID-19 Test Kit Claim Form (available on the Health Fund's website or call the Health Fund office), and with such proof of purchase, as the Fund Administrator reasonably requires.

This coverage shall be effective for purchases made on or after January 15, 2022 and shall automatically expire upon the expiration of the National Health Emergency or such earlier date as the law allows.

The Operating Engineers Local 139 Health Benefit Fund has adopted the following changes to the Economy Plan, effective June 1, 2022:

1. The in-network Infertility Benefits will be covered at $10,000 per person per lifetime for medical claims and $10,000 per person per lifetime for prescription drug benefits, as set forth in the ***Summary of Benefits***.

2. Insert the following new paragraph to the "Annual Deductibles" subsection on page 22 immediately above the "Example:"

   Covered Expenses, which are for Protected Services and / or Continuing Care Services, will apply to satisfy the annual deductible, as if such Services were furnished by an in-network provider.

3. Insert the following new paragraph to the end of "Annual Out-Of-Pocket Maximum" subsection on page 23:

   Covered Expenses, which are for Protected Services and/or Continuing Care Services, will apply to satisfy the annual out-of-pocket maximum, as if such Services were furnished by an in-network provider.

4. The second paragraph in the "Preferred Provider Organization (PPO) Network" section on page 23 is amended to read as follows:

   Note: The Fund primarily does not cover the costs of services you receive from providers who do not participate in the PPO network. However, Protected Services (for example, certain Emergency Services) and Continuing Care Services, are covered by the Plan (refer to page 23) even when you receive them from out-of-network providers. If a service is covered, it's important for you to understand that out-of-network providers (where allowed) are not obligated to discount their fees. This means you and the Fund pay more when you use their services, and they ~~can~~ may be able to balance bill you for services other than Protected Services or Continuing Care Services. Your deductible, coinsurance, and out-of-pocket maximums ~~are~~ may also be higher when you use out-of-network providers for services other than Protected Services or Continuing Care Services.

5. The "Out-of-Network" section on page 23 is amended to read as follows:

   Out-of-Network

   The Plan maintains a broad network of providers who are part of the PPO network. Out-of-network benefits are not covered under the Plan, subject to the following exceptions:

   - In the event of an emergency, out-of-network treatment and services are covered. This also applies to emergency ambulance services. Protected Services and Continuing Care Services are covered by the Plan.

   - Medically Necessary radiologist, pathologist, anesthesiologist, and emergency room Physician and laboratory technicians are Covered Expenses when performed at a network facility or doctor's office,

regardless of whether or not the provider is a Preferred Provider, on the terms set forth in the previous section

- Chiropractic therapy
- Acupuncture
- Hearing aids
- Prescription drugs
- Continuing Care Services
- Cologuard test kits

Although the Plan covers the above-listed services when provided by out-of-network providers, they are still 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 applicable law ~~except if otherwise prohibited by law~~.

6. Insert the following new paragraph at the end of the subsection "Emergency Room Additional Coinsurance" on page 24:

   This provision (and all Plan provisions) shall be interpreted to apply consistently with the No Surprises Act, including its limitations on amounts, which a Covered Person can be required to pay.

7. Insert the following new sentence to the end of the first paragraph of the "Surgical Benefits" subsection on page 28:

   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 will be covered as if the emergency department is a hospital, as required by law.

8. Strike paragraph 31 of the "Comprehensive Medical Benefit Exclusions And Limitations" section on page 35.

9. Insert the following new section after the "Appeal Decisions" section and before the "Coordination of Benefits" Section on page 52:

   External Review

   If the Trustees deny your appeal, you may further 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 to obtain the appropriate forms.

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

- You, or your Dependent, was covered under the Plan at the time the health care item or service was provided;
- The adverse benefit determination on appeal does not relate to your, or your Dependent's, failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
- You, or your Dependent, exhausted the Plan's internal appeal process; and
- You, or your Dependent, has provided all the information and forms required to process an external review.

Within 1 business day after completion of the preliminary review, the Fund will issue a notification in writing to you regarding whether your claim is eligible for external review. If the request is complete, but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification shall describe the information or materials needed to make the request complete and the Fund must allow you to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later. If the request is complete and eligible for review, the Fund will assign the matter for external review as described below.

The Fund will assign an IRO to conduct the external review. The IRO 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.

The Fund Office will provide documents and any information considered in making the adverse benefit determination or final, internal, adverse benefit determination to the IRO.

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

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Plan Administrator, you, or your treating provider;
- The terms of the Plan;

- Evidence-based practice guidelines;

- Any applicable clinical review criteria developed and used by the Plan Administrator; and

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

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.

If there is a reversal of the Fund's decision, upon receipt of the notice of final external review decision reversing the adverse benefit determination, the Fund will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim. If the Fund disagrees with the IRO's determination, it may sue you or your representative to recover the benefits paid after the IRO's determination.

An external review does not extend the time to file an action in court under ERISA, as described in the "Appeal Decisions" section on pages 76-77. For purposes of calculating the two-year time period for initiating a lawsuit, the IRO's determination is not considered to be the Fund's determination. That is, the two years runs from the date of the Fund's determination, not the IRO's determination.

10. The term "Allowable Charge" in the Glossary on page 64 is modified to add the following new sentence to the end of such definition:

    For Protected Services, the Allowable Charge shall be the amount determined under the No Surprises Act, to the extent required by applicable law.

11. The term "Usual, Customary, and Reasonable" in the Glossary on page 70 is amended to add the following new sentence to the end of the definition:

    For Protected Services furnished by an out-of-network provider, the Usual, Customary, and Reasonable amount is based on an amount required under the No Surprises Act (a federal law). Continuing Care Services are also paid at a similar level, as required by applicable law.

12. The following terms are added to the Glossary on pages 64-70 in their proper alphabetical location:

    "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 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

- 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).

- 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").

- 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 non-medical 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.

The Operating Engineers Local 139 Health Benefit Fund has adopted the following change to the Economy Plan, effective August 1, 2022:

Replace the second to last paragraph in the "Covered Prescription Drug Expenses" subsection on page 33 with the following:

The Plan does cover medications related to treatment of attention deficit and attention deficit hyperactivity disorders. However, as with all benefits, the medication must be medically necessary.

The Operating Engineers Local 139 Health Benefit Fund has adopted the following change to the Economy Plan, effective September 1, 2022:

Replace "Metropolitan Life Insurance Company (MetLife) with Voya (ReliaStar Life Insurance Company (ReliaStar Life)) in the "Death and Dismemberment Benefits" section on page 43, the "Death and Dismemberment Claims" subsection on page 49, and the "Death and Dismemberment Benefit Claims" subsection on page 50.

The Operating Engineers Local 139 Health Benefit Fund has adopted the following change to the Economy Plan, effective December 1, 2022:

Replace the fourth bullet point on page 40 in the "Transplant Benefit Exclusions and Limitations" subsection as follows:

- **Experimental or Investigative**, except for medically necessary drug therapy following organ transplant for treatment of antibody mediated rejection where two or more other therapies have failed.

The Operating Engineers Local 139 Health Benefit Fund has adopted the following changes to the Economy Plan, effective January 1, 2023:

1. Remove all references to Heath Dynamics in the ***Summary of Benefits***.
2. "Routine Physical Examination Benefits" section on page 27 under "Covered Expenses" is replaced in its entirety with the following.

Routine Physical Examination Benefits

The Plan covers 100% of routine physical examinations for you and your eligible Dependents.

For You and Your Spouse

The Plan covers an annual physical examination for active Participants and their spouses. If the exam is performed by your Physician in his or her office or a Hospital, the Plan covers the exam, laboratory tests, X-rays, mammogram (including digital mammograms), Pap smear, and prostate exam (PSA) at 100%.

For Your Dependent Children

Physicians recommend periodic office visits for well childcare. During the first 24 months of your child's life, these occur at frequent intervals. The Plan covers routine physical examinations for your Dependent children as specified on the

Summary of Benefits insert (in the back pocket of this booklet).

Note: The Fund allows for one pediatrician visit in the Hospital after birth. Any additional charges for Physician visits while a well newborn is an inpatient are not covered.

Pap Smear and Mammogram Benefits

The Plan covers one pap smear and/or mammogram per calendar year.

Colorectal Cancer Screening Benefits

The Plan covers colorectal cancer screenings. In some instances, limited types of screenings for colorectal cancer may be included in an exam, such as fecal occult blood testing (FOBT), which a Physician can perform. However, other types of screening procedures normally cannot be provided and, therefore, you must be referred to a specialist. In these instances, the screenings are not covered.

For average-risk individuals age 45 and older, the Plan covers one fecal occult blood test (FOBT) each year and:

- One sigmoidoscopy every five years
- One double-contrast barium enema (DCBE) every five years or
- One colonoscopy every 10 years

The Plan also covers:

- Screening with annual FOBT, either alone or in conjunction with sigmoidoscopy, beginning at age 45
- Colorectal cancer screening (tests and frequency as outlined above) beginning at age 40 covered for persons with a single first-degree relative (sibling, Parent, or child) with a history of colorectal cancer or an adenomatous polyp
- Colorectal cancer screening with the Cologuard test kit beginning at age 45, as frequently as every three years, for individuals at average risk for colon cancer
- Screening with sigmoidoscopy, DCBE, or colonoscopy covered as frequently as every two years for individuals with one or more of the following high-risk factors for colorectal cancer:
  - A first-degree relative (sibling, Parent, child) who has had colorectal cancer or an adenomatous polyposis (screening covered beginning at age 40 years)
  - Family history of familial adenomatous polyposis (screening covered beginning at puberty) and/or
  - Family history of hereditary nonpolyposis colorectal cancer (HNPCC) (screening covered beginning at age 20 years)

- Colorectal cancer surveillance with colonoscopy, flexible sigmoidoscopy or DCBE covered as frequently as every two years for individuals who meet any of the following criteria:

  - Patient has inflammatory bowel disease, including ulcerative colitis or Crohn's disease (colorectal cancer surveillance covered as frequently as every two years)

  - Personal history of adenomatous polyps (surveillance covered as frequently as every two years) and/or

  - Personal history of colorectal cancer (surveillance covered as frequently as every two years)

Union Trustees

2-14-2023
Dated

Employer Trustees

2/14/2023
Dated