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

The Operating Engineers Local 139 Health Benefit Fund has adopted the following changes to the Summary Plan Description/Plan Document, 2026 Edition effective January 1, 2026.

1. ~~To clarify the long-standing interpretation of existing plan language, amend paragraph 18 of the **Comprehensive Medical Benefit Exclusions And Limitations** section on page 48, to include a subsection f. as follows:~~

   ~~f. Medication prescribed for a use (*i.e.*, off-label use) that is not an FDA-approved treatment for the patient's diagnosis or condition.~~

   Withdrawn by Amendment Two

2. ~~To clarify the long-standing interpretation of existing plan language, add paragraph 34 to the **Comprehensive Medical Benefit Exclusions And Limitations** section on page 48 as follows:~~

   ~~34. Medication prescribed for a use (*i.e.*, off-label use) that is not an FDA-approved treatment for the patient's diagnosis or condition.~~ Withdrawn by Amendment Two

3. ~~To clarify the long-standing interpretation of existing plan language, the Glossary definition of **Experimental** and **Investigational** on page 90 is amended to add a fifth bullet point at the end of the definition that reads:~~

   Withdrawn by Amendment Two

   - ~~Is an off-label use of an FDA approved medication for the patient's diagnosis or condition~~.

4. The Glossary definition of **Medically Necessary** or **Medical Necessity** on page 92 is removed and replaced with the following:

   Medically Necessary or **Medical Necessity** means that a specific service or supply is required to treat your condition. Medically Necessary expenses include expenses that:

   - Are appropriate and consistent with a medical diagnosis provided by a legally qualified Physician or surgeon operating within the scope of his or her license;
   - Medical necessity may require support by records from a licensed physician other than the physician or operating surgeon.
   - Are in accordance with the acceptable standards of community practice; and
   - Could not have been omitted without adversely affecting either you or your eligible Dependent's condition or quality of medical care. Inpatient care in a Hospital is Medically Necessary only if treatment for the Illness or Injury cannot be provided safely on an outpatient basis.

   A service or supply is not automatically considered Medically Necessary just because it is prescribed by a Physician or other medical provider.

   Skin removal surgeries, such as panniculectomy following significant weight loss, will only be considered Medically Necessary if all of the following criteria are met:

- When the excess skin causes a documented, chronic medical condition resulting in functional impairment and has failed prescribed medical treatment (e.g., chronic dermatitis, recurrent infection, ulceration, or skin breakdown) resulting in pain, bleeding, drainage, or interference with hygiene, ambulation, work, or activities of daily living. Failure to follow conservative and medical treatments to manage the chronic condition is not acceptable.

- Chronic conditions must persist for at least three (3) consecutive months or recur three (3) or more times within a twelve (12) month period.

- Over-the-counter and/or self-directed treatment alone is insufficient to establish medical necessity.

- Medical necessity, including the establishment of chronic conditions over the period of time noted above, must be supported by records from a licensed physician, other than the operating surgeon.

- If medically necessary skin removal follows significant weight loss, a licensed physician, other than the operating surgeon, must provide a letter verifying that the desired weight loss goal has been met to ensure that redevelopment of chronic conditions is unlikely.

- Coverage, if approved, is limited to the minimum surgical intervention necessary to treat the documented medical condition. There is no coverage if additional cosmetic procedures are performed in the same surgery.

5. The Summary of Benefits is amended to remove the Hearing Care Benefit from the section titled "Benefits With In-Network & Out-of-Network Coverage" and create a new section as follows:

Hearing Care Benefits **(90% coverage, subject to deductible)**	
Hearing Examination	One exam per person per calendar year
Hearing Aids (Provider Services)	$6,000 per person in any 72-month period
Hearing Aid Repair	$300 per person per calendar year