# PLUMBERS & STEAMFITTERS LOCAL 166
# BENEFIT FUNDS
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January 2023

**To: Plumbers and Steamfitters Local 166 Health & Welfare Fund Participants**

**From: Board of Trustees Plumbers and Steamfitters Local 166 Health & Welfare Fund**

Please read this Notice carefully as it contains important information regarding changes to coverage under the Plumbers and Steamfitters Local 166 Health & Welfare Fund**.** Please keep this Notice with your Summary Plan Description (SPD).

## PLAN CHANGES

### Weekly Disability

Please be advised that effective for all new disabilities dated on or after January 1, 2023, weekly disability will now be available for up to 20 weeks (previously 15 weeks) per year as the following amounts:

- Apprentice: $650.00 per week
- Journeymen: $750.00 per week.

In addition, effective August 23, 2022, weekly disability will be available to a First Responder Military Personnel, or Veteran receiving disability compensation as a result of an injury incurred while serving in the Military or employed as a First Responder, provided the Participant is an Active Employee, as defined by the Plan, at the time of their application. For purposes of this provision, "First Responder" means firefighter, law enforcement officer, paramedic, or emergency medical technician.

All other terms and conditions regarding Weekly Disability Benefits currently contained in your Plan document remain the same.

### No Surprises Act – Effective January 1, 2022

Due to changes in the law, several changes were made to the coverage offered by the Fund effective January 1, 2022, which can be summarized as follows:

(1) Emergency Services –

- If you have an emergency medical condition and get emergency services from an out-of-network provide or facility, the most you can be billed is the Plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). In other words, you cannot be balance billed for emergency services.[1] This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

[1] Balance billing occurs when an out-of-network provider bills you for the difference between the amount the Plan will pay, and the full amount charged for the service. This amount is likely more than in-network costs for the same services.

- You are not required to get approval for emergency services (otherwise known as prior authorization).

- Any amount you pay for emergency services must count toward your in-network deductible and out-of-pocket limit.

- For purposes of these protections, an "emergency medical condition" means a medical condition (including a mental health condition or substance use disorder) which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the lack of immediate medical attention would place the health of the individual (or, as to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(2) In-network hospital or ambulatory surgical center – When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In general, in these cases, the most those providers may bill you is your plan's in-network cost-sharing amount for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, diagnostic services (excluding advanced diagnostic services), and items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility. These providers cannot balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers cannot balance bill you, unless you give written consent and give up your protections.

(3) Coverage for Air Ambulance: If you require air ambulance services, the most you can be billed is the Plan's in-network cost sharing amount. You cannot be balance billed.

(4) Continuity of Care: Plans must notify individuals who are continuing care patients of the right to continue care after termination of provider/facility contract (e.g., when an in-network provider becomes out-of-network).

(5) External Review: The Plan was amended to apply external review procedures to adverse determinations regarding emergency services and air ambulances.

**Please find a more detailed summary of changes made to the SPD in light of the above.**

**Change to the Incentive Program**

Effective January 1, 2022, Participants no longer have to meet tailored health goals over a 12-month period to receive a $100 incentive payment under Section 3.9(d) of the Plan.

Instead, Participants simply need to complete their physical and participate in the health coaching program within 6 months of completing their annual physical (no health goals required) to receive their $100 incentive payment.

## CHANGES EFFECTIVE JANUARY 15, 2022

The Plan was clarified to indicate that as required by law, COVID-19 Testing will be covered by the Plan if it is ordered by a health care provider.

In addition, the Plan was amended to cover up to 8 tests COVID-19 testing for personal use (e.g. not employment purposes) per 30 days per Covered Person, as required by law. To be covered, the tests must be processed through your pharmacy card with coverage as follows:

- in-network: 100%;
- out-of-network: reimbursement provided up to lesser or actual price of test or $12.

## CHANGES EFFECTIVE MARCH 22, 2022

The Plan was amended to provide that the Plan Liaison will be provided a written list of Retirees and Surviving Spouses who have failed to timely make their self-payment. The Plan Liaison will investigate whether there is good cause for failure to timely remit this payment and will advise the Fund Office. If there is good cause, coverage will not be terminated provided the required self-payment is received within 30 days of the original due date.

## CHANGES EFFECTIVE MAY 31, 2022

Effective May 31, 2022, the colon/rectal screening benefit is as follows:

| Medical Benefits | In-Network | Out-of-Network |
|---|---|---|
| Colon/rectal screening under age 45 (one per every 10 years if age 35-44, or one per every 10 years if under age 35 and considered high risk). This may be a colonoscopy or non-invasive stool-based test (e.g., Cologuard) (if the Covered Person selects a non-invasive stool-based test and is thereafter referred for a colonoscopy, the colonoscopy will then be covered as a diagnostic procedure). | 100% | 50% |
| Colon/rectal screening ages 45-75 covered as required by federal law. This may be a non-invasive stool-based test (e.g., Cologuard), a colonoscopy, or other direct visualization test (e.g., flexible sigmoidoscopy or CT colonography).<br><br>If a Covered Person has abnormal findings identified by the flexible sigmoidoscopy or CT colonography, or a positive result on a stool-based screening test, then a follow-up colonoscopy will be covered as a preventative care benefit.<br><br>The frequency of coverage for this preventative care benefit depends on the screening tool used. For example, the current recommendations provide:<br>• Colonoscopy: once every 10 years;<br>• Flexible sigmoidoscopy or CT colonography: once every 5 years<br>• Non-invasive stool-based test (e.g., Cologuard): once every one to three years.<br><br>The Plan will continue to follow the United States Preventative Services Task Force "A" and "B" recommendations to determine the screening frequency. | 100% | 50% |

If you have any questions, please contact the Fund Office.

Sincerely,

The Board of Trustees
W2588204

## EXHIBIT A

**(1)** **Definitions -** The following definitions are added:

**Ancillary Services** means emergency medicine, anesthesiology, pathology, radiology, and neonatology whether provided by a participating or Nonparticipating provider; items and services provided by assistant surgeons, hospitalists, and intensivists; and diagnostic services, including radiology and lab services (excluding certain advanced diagnostic laboratory tests per federal guidance or rulemaking).

**Consent to Out of Network Services** means:

(a) a covered person provided informed consent under applicable law to receive either:
  (1) post-stabilization services following Emergency Services from an out-of-network provider or out-of-network emergency facility; or
  (2) nonemergency services from an out-of-network provider at an in-network facility; and

(b) the Plan receives notice of such consent.

Notwithstanding, Consent to Out of Network Services does not include Ancillary Services or items or services provided as a result of unforeseen, urgent medical needs that arise at the time an items or service is furnished or if rendered by a Nonparticipating provider when a Participating Provider is unavailable.

**Continuing Care Patient** means a covered person who, with respect to a provider or facility—

(a) is undergoing a course of treatment for a Serious and Complex condition;
(b) is undergoing a course of institutional or inpatient care;
(c) is scheduled to undergo nonelective surgery, including receipt of postoperative care with respect to such a surgery;
(d) is pregnant and undergoing a course of treatment for the pregnancy; or
(e) is or was determined to be terminally ill (i.e., a medical prognosis that the individual's life expectancy is 6 months or less) and is receiving treatment for the terminal illness.

**Emergency Medical Condition** means a medical condition (including a mental health condition or substance use disorder) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

**Emergency Services** with respect to an Emergency Medical Condition means:

(a) a medical screening examination, in compliance with the Emergency Medical Treatment and Labor Act, that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, including ancillary services routinely available to the emergency department, to evaluate such Emergency Medical Condition, and
(b) medical examination and treatment that are within the capabilities of the staff and facilities available at such hospital or independent freestanding emergency department as required to Stabilize the patient (regardless of the department of the hospital in which such items or services are furnished), and
(c) unless Consent to Out of Network Services is provided to the Plan by the provider or facility, items and services for which benefits are provided by the Plan that are furnished by a nonparticipating provider or nonparticipating emergency facility after the Covered Person is Stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the Emergency Medical Condition which gave rise to the initial Emergency Services.

**Qualifying Payment Amount (QPA)** for an item or service means the median in-network rate for (a) the same or similar services; (b) furnished in the same or a similar facility; (c) by a provider of the same or similar specialty; and (d) in the same or similar geographic area, adjusted as required by applicable regulations for inflation and base billing units, if applicable.

**Recognized Amount** with respect to an item or service furnished by a nonparticipating provider is: (1) for an item or service furnished in a State that has an All-Payer Model Agreement under 1115A of the Social Security Act, the amount the State approves under such system; (2) if there is no applicable All-Payer Model Agreement, an amount determined by a specified by State law where the item or service is furnished; or (3) if neither of the above apply, the lesser of (a) the amount billed by the provider or facility or (b) the Qualifying Payment Amount (QPA).

**Serious and Complex Condition** means

(a) 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

(b) 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.

**Stabilize**d means, with respect to an Emergency Medical Condition, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

**(2) The following is added to Article 3, Section 3.1, Networks:**

**Services Provided by Nonparticipating Provider at Participating Facility:** Notwithstanding any term of the Plan to the contrary, where covered nonemergency items or services are provided by nonparticipating providers at participating facilities, in the absence of Consent to Out of Network Services, the Plan will:

(a) not impose a cost sharing requirement greater than the requirement that would apply if the items or services were provided by a participating provider;

(b) calculate cost-sharing as if the total amount that would have been charged for the items or services by a participating provider were equal to the Recognized Amount for such services; and

(c) apply any cost-sharing payments with respect to such items and services toward any in-network deductible or in-network out-of-pocket maximums the same as if the services were received in-network.

**Continuing Care Patient:** If a covered person is a Continuing Care Patient of a provider or facility that terminates its participating provider status with the Plan as a result of: (a) termination of its contractual relationship as a participating provider (not including termination of the contract for failure to meet quality standards or fraud), or (b) termination of benefits under the Plan due to a change in the terms of the participation of the provider or facility in the network, the Plan will:

a) notify each Continuing Care Patient on a timely basis of such termination and such individual's right to elect continued transitional care from such provider or facility as set forth in c), below;

b) provide such individual with an opportunity to notify the Plan of the individual's need for transitional care; and

c) allow such individual to elect to continue to benefits provided under the Plan under the same terms and conditions as would have applied to the individual as a Continuing Care Patient had such termination not occurred, during the period beginning on the date on which the notice under

a), above, is provided and ending on the earlier 90 days or the date on which such individual is no longer a Continuing Care Patient with respect to such provider or facility.

**(3) Changes to the Schedule of Benefits in Article 3, Section 3.2(b)**

The Hospital Services section of the Schedule of Benefits was revised to remove the reference to "Emergency Room" and instead to provide for "Emergency Services for an Emergency Medical Condition". The Hospital Services portion of the Schedule of Benefits now states as follows:

| Medical Benefits | In-Network | Out-of-Network |
|---|---|---|
| **HOSPITAL SERVICES** (whether admitted as bed patient or as an outpatient to any state-approved hospital) | | |
| Emergency Services for an Emergency Medical Condition (per incident or occurrence) (no deductible)<br><br>If Emergency Room Visit results in admission see below. | 80% with $200 copayment | 80% of the Recognized Amount after $200 copayment (in-network out-of-pocket maximums apply and this co-insurance and copayment for these Emergency Services to be counted towards in-network out of pocket maximums). |
| Emergency Services for an Emergency Medical Condition - resulting in admission (no deductible) | 80% | 80% of the Recognized Amount (in-network out-of-pocket maximums apply and this co-insurance and copayment for these Emergency Services to be counted towards in-network out of pocket maximums). |

In addition, the Ambulance Services section of the Schedule of Benefits was revised to add coverage for Air Ambulance. The Ambulance Services portion of the Schedule of Benefits now states as follows:

| Medical Benefits | In-Network | Out-of-Network |
|---|---|---|
| **OTHER PROVISIONS** | | |
| Ambulance Services<br>Trips must be to the closest facility that can give covered services appropriate for the Covered Person's Emergency Medical Condition or to and from Hospital for a covered admission. Air ambulance service is covered under the Plan when Medically Necessary. | 80% | Ground Ambulance: 80%<br><br>Air ambulance: 80% of lesser of billed charges or the Qualified Payment Amount, after deductible (in-network deductible and in-network out-of-pocket maximums apply and this co-insurance and deductible for air ambulance to be counted towards in-network out of pocket maximums). |

**(4) Changes to Article 8, Section 8.1, Eligibility for External Review**

The scope of eligibility for external review was expanded. Article 8, Section 8.1, now states that the external review process applies to any final internal adverse benefit determinations that involves:

> The external review process applies to any final internal adverse benefit determination that involves (1) medical judgment, including, but not limited to, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or experimental or investigational treatment (excluding, however, determinations that involve only contractual or

legal interpretation without any use of medical judgment); (2) whether the Plan is complying with the nonquantitative treatment limitation provisions which, in general require parity in the application of medical management techniques; (3) consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in ERISA sections 716 and 717; or (4) a rescission of coverage (whether or not the rescission has any effect on any particular benefits at that time). Weekly disability benefits are not subject to external review. A denial, reduction, or termination, or a failure to provide payment for a benefit based on a determination that a Claimant fails to meet the requirements for eligibility under the terms of the Plan, or based on a Plan exclusion, is not eligible for the external review process.

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# Important Plan Information