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PLUMBERS LOCAL 98
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To: Plumbers Local 98 Insurance Fund Participants

From: Board of Trustees of the Plumbers Local 98 Insurance Fund

Re: Summary of Material Modification – KEEP WITH SUMMARY PLAN DESCRIPTION

Date: October 2022

Please read this Notice carefully as it contains important information about changes to the Plumbers Local 98 Insurance Fund Plan (Plan). This document should be read carefully and attached to your Plumbers Local 98 Insurance Fund Summary Plan Document (SPD). Please contact the Fund Office if you have any questions about the changes described in this Notice.

PLAN CHANGES EFFECTIVE SEPTEMBER 1, 2022

No Surprises Act

Due to changes in the law, several changes were made to the coverage offered by the Fund effective September 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 provider 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.

- You are not required to get prior authorization for emergency services.

- Any amount you pay for emergency services or out-of-network 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

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

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, 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.

Attached as Exhibit A please find a more detailed summary of changes made to the Plan and SPD regarding the above changes.

PLAN CHANGE EFFECTIVE AUGUST 1, 2022

Effective August 1, 2022, telehealth through MDLive is no longer a benefit under the Plan.

PLAN CHANGES EFFECTIVE JUNE 1, 2022

Pensioner and Surviving Spouse Self-Pay Deductions

Until recently, Pensioners and Surviving Spouses have had the option to maintain coverage under the Plumbers Local 98 Insurance Fund by having their monthly self-payment deducted from the pension benefit provided by the Plumbers Local 98 Defined Benefit Pension Plan. Effective with the Insurance Fund self-payment due June 1, 2022, this pension deduction became mandatory for anyone receiving a pension benefit that is enough to cover their monthly Insurance Fund self-payment. However, those with balances in their Health Reimbursement Account (HRA) can have self-payments deducted from the HRA first. If this option is chosen, once the HRA is depleted the deduction will automatically begin from the pension benefit.

Eligibility Rules

Eligibility for the Plan will terminate immediately for an individual who works for a noncontributing employer performing work of the type for which Contributions would have to be paid to the Fund if performed for a contributing Employer under the Collective Bargaining Agreement. If the Plan Office determines there is a

pattern of activity which suggests you are using the Bank and/or self-payment systems to extend eligibility for periods of time during which you do not intend to work, or are not working, in the plumbing industry for a contributing Employer, then upon submission of such evidence to the Trustees, the Trustees may immediately terminate your eligibility and you will not be entitled to continue coverage by way of Bank or self-payments.

Further, the balance in your HRA will be remitted to the Fund and permanently lost (i.e. you will lose this benefit, even if you later reestablish eligibility) if your eligibility is terminated because either: (1) you work for a non-contributing employer performing work of the type for which Contributions would have to be paid to the Fund if performed for a contributing Employer under the Collective Bargaining Agreement, or (2) you work for an employer who is not in the plumbing and pipefitting industry and you are not available for work for a contributing employer.

NOTE ON PREVENTIVE CARE

The Plan covers, as required by law, preventive care without cost sharing if obtained in-network. The preventive care required to be covered by law changes from time to time. For a list of items currently covered, please reference your SPD and www.healthcare.gov/coverage/preventive-care-benefits/.

If you have any questions please call the Plan Administrator at (845) 278-9633. Please keep this Notice with your Summary Plan Description (SPD).

Exhibit A

(1) Definitions

These definitions have been added to the Plan and SPD at Article 1:

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 item or service is furnished.

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).

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 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 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.

Stabilized 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) <u>Networks</u>

Article 5, Section 5.1 in the Plan and SPD has been restated as follows:

5.1. Networks

The Fund has contracted with a preferred provider network. A list of the physicians participating in this network (the Provider Directory) is available at the Plan Office, free of charge. If a Plan Participant receives covered services from a provider who is not a Participating Provider because he or she reasonably relied on incorrect information from the Provider Directory, then the Plan Participant will only be responsible for the Participating Providers' copayment, deductible, or coinsurance. Participants and their Dependents may choose to receive treatment from an out-of-network provider but will generally incur greater out of pocket expenses if they do so.

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

allow such individual to elect to continue 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) <u>Changes to Schedule of Benefits</u>

The Emergency Room section of the Schedule of Benefits at section 5.2 of the Plan and SPD for Emergency Services, Ground Ambulance, and Air Ambulance has been revised as follows:

	Full Plan		**Standard Plan**		**Basic Plan**	
Medical Benefits	**In-Network**	**Out-Of-Network**	**In-Network**	**Out-Of- Network**	**In-Network**	**Out-Of-Network**
Outpatient Care						
Emergency Services for an Emergency Medical Condition	For out of network expenses for Emergency Services for an Emergency Medical Condition, the in-network out-of-pocket maximums apply and the out of network co-insurance and copayment counted towards in-network out of pocket maximums.					
Facility/Physician Co-pay is waived if emergency care is for accidental injury or if admitted.	100% after $250 copay*	100% of the Recognized Amount after $250 copay*	100% after $350 copay*	100% of the Recognized Amount after $350 copay*	100% after $450 copay*	100% of the Recognized Amount after $450 copay*
Lab/X-Ray/ Diagnostic Testing	90%*	90% of the Recognized Amount*	80%*	80% of the Recognized Amount*	70%*	70% of the Recognized Amount*

	Full Plan		Standard Plan		Basic Plan	
Medical Benefits	**In-Network**	**Out-Of-Network**	**In-Network**	**Out-Of- Network**	**In-Network**	**Out-Of-Network**
Other Services						
Ground Ambulance (up to 2 trips per confinement)	90%*	80% UCR**	80%*	70% UCR**	70%*	60% UCR**
Air Ambulance (when Medically Necessary)	90%*	90% 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).	80%*	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).	70%*	70% 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).

*Plan pays after satisfaction of in-network deductible. **Plan pays after satisfaction of out-of-network deductible.

(4) External Review Process

Article 12, Section 12.1 of the Plan and SPD, Eligibility for External Review, has been revised as follows:

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