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IMPORTANT NOTICE ABOUT CHANGES TO THE INTERNATIONAL UNION OF OPERATING ENGINEERS LOCAL 132 HEALTH AND WELFARE FUND SUMMARY PLAN DESCRIPTION

This Notice explains important changes that are being made to the Summary Plan Description of the International Union of Operating Engineers Local 132 Health and Welfare Fund. You are urged to carefully review this Notice and address any questions to the Benefit Office. This Notice should be kept with your records of Plan activities.

Protections from Surprise Medical Bills

Effective July 1, 2022, you will have protection against surprise medical bills from out-of-network providers and facilities under a new federal law called the No Surprises Act. This law mainly applies to Out-of-Network **Emergency Services**, services provided by out-of-network providers at network facilities, and Out-of-Network **Air Ambulance Services**.

Terms that are bolded throughout this Notice are defined in the Definitions section below.

Out-of-Network Emergency Services

Covered **Emergency Services** are treated as In-Network for determining all cost-sharing amounts, including the coinsurance, copayments, deductible, and the out-of-pocket maximum, even if the services were received from an **Out-of-Network Emergency Facility**. This means you will be responsible for the network cost-share amount. The Plan will count any cost-sharing payments toward the in-network deductible and/or the in-network out-of-pocket maximums in the same manner it would count cost-sharing payments made for in-network **Emergency Services**.

Your cost-sharing will be based on the **Recognized Amount** payable for these services.

If you receive **Emergency Services** from an out-of-network provider, the provider is not permitted to "balance bill" you for the difference between what the provider charges and the total amount collected by the provider, which include payments paid by the Plan and copayments, coinsurance, or deductible amounts paid by you.

Out-of-Network Providers at Network Facilities

Unless you consent to receiving services from the out-of-network provider (as described in this section), covered services performed by out-of-network providers with respect to visits at **Network Health Care Facilities** are treated as in-network for determining all cost-sharing amounts, including the coinsurance, copayments, deductible, and the out-of-pocket maximum.

This means you will be responsible for the network cost-share amount, and the Plan will count any cost-sharing payments incurred for these services toward the in-network deductible and/or the in-network out-of-pocket maximums under the Plan in the same manner it would count cost-sharing payments made for in-network services.

Your cost-sharing will be based on the **Recognized Amount** payable for these services.

If you receive services from an out-of-network provider at a network facility, the provider is not permitted to "balance bill" you for the difference between what the provider charges and the total amount collected by the provider, which include payments from the Plan and copayments, coinsurance, or deductible amounts paid by you.

Out-of-Network Air Ambulance Providers

Covered **Air Ambulance Services** are treated as in-network for determining all cost-sharing amounts, including the coinsurance, copayments, deductible, and the out-of-pocket maximum. This means you will be responsible for the network cost-share amount and the Plan will count any cost-sharing payments incurred for covered **Air Ambulance Services** toward the in-network deductible and/or the in-network out-of-pocket maximums in the same manner it would count cost-sharing payments made for in-network services.

Your cost-sharing will be based on the lesser of the amount billed by the provider or facility or the **Qualifying Payment Amount**.

If you receive **Air Ambulance Services** from an out-of-network provider, the provider is not permitted to "balance bill" you for the difference between what the provider charges and the total amount collected by the provider, including payments from the Plan and copayments, coinsurance, or deductible amounts paid by you.

Waiving Surprise Medical Bill Protections

In certain limited circumstances, you can waive the balance billing and cost-sharing protections provided under the No Surprises Act. You may be able to waive these protections for (1) services from an Out-of-Network Provider with respect to a visit at a **Network Health Care Facility** or (2) services from an **Out-of-Network Emergency Facility** or provider after you are stabilized. This can occur if you are notified by the Out-of-Network Provider that the provider does not participate with the Plan and you provide informed consent to be treated by the provider and waive the protections.

If you give informed consent to be treated by the Out-of-Network provider, then the Plan will treat these services as Out-of-Network. This means you will be subject to Out-of-Network cost-sharing, the provider can bill you for the balance directly, and the provider can balance bill you for the difference between what the provider charges and the amount paid by the Plan and the cost-sharing amounts paid by you.

You may not waive No Surprises Act protections for ancillary services provided by an Out-of-Network Provider in a **Network Health Care Facility**. Ancillary services include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic

services, including radiology and laboratory services; and items and services provided by an out-of-network Provider if there is no in-network Provider who can furnish such item or service at such facility.

Payments to Out-of-Network Providers at Network Facilities, Out-of-Network Air Ambulance Providers, and Out-of-Network Emergency Facilities

For claims subject to the No Surprises Act from Out-of-Network Providers at **Network Health Care Facilities**, Out-of-Network Air Ambulance Providers, and Out-of-Network Emergency Facilities, the Plan will pay the provider or facility the **Out-of-Network Rate** minus any cost-sharing amounts (copayments, coinsurance, and/or amounts paid towards deductible) you paid.

Continuing Care

If you are receiving care from a network provider that becomes out-of-network, you may have certain rights to continue your course of treatment if you are a "continuing care patient."
A continuing care patient is a patient that

- is undergoing a course of treatment for a serious and complex condition from the provider or facility;
- is undergoing a course of institutional or inpatient care from the provider or facility;
- is scheduled to undergo nonelective 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 (as determined under Social Security Act) and is receiving treatment for such illness from such provider or facility.

A serious and complex condition means a condition that

- in the case of an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- 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.

If the Plan terminates its contract with your Network provider or facility or your benefits are terminated because of a change in terms of the providers' and/or facilities' participation in the Plan, you will be notified of the change and informed of your right to elect to receive transitional care from the provider. You may choose to continue your course of treatment under the same terms and conditions as would have applied for an in-network provider for up to 90 days after the notice is provided or until you no longer qualify as a continuing care patient (whichever is earlier). These providers cannot balance bill you during this time.

Termination of a contract includes the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

Provider Directory

If you rely on information in the Plan's provider directory that inaccurately states that an out-of-network provider is in-network, you will only be subject to in-network cost sharing amounts. These

cost-sharing amounts will be applied toward the in-network deductible and/or in-network out-of-pocket maximum in the same manner in-network cost-share would be applied.

External Review

You may request an external appeal review after an initial Claim Denial and subsequent internal review appeal denial to dispute determinations that involve whether the Plan complied with the surprise billing and cost-sharing protections under the No Surprises Act. The process for an external review is as follows:

Request for External Review
An external appeal must be allowed if you request an external appeal within four months after receipt of notice of Claim Denial or appeal denial. An immediate external review must also be allowed if the Plan has failed to adhere to the appeals regulations unless the violation was: 1) de minimis; 2) non-prejudicial; 3) attributable to good cause or matters beyond the Plan's control; 4) in the context of an ongoing good-faith exchange of information; and 5) not reflective of a pattern or practice of non-compliance. If the Plan asserts an exception, you are entitled, upon written request, to an explanation of the Plan's basis for asserting the exception. If the external reviewer rejects your request for immediate review on the basis that the Plan has met the five-element exception, you are permitted to resubmit and pursue and internal appeal.

Preliminary Review
The preliminary review of the external appeal must be completed within five business days after receipt of request to determine whether:

- You were covered under the Plan at the time the health care item or service was provided;
- The initial Claim Denial or internal review Claim Denial did not relate to your failure to meet eligibility requirements for eligibility under the Plan;
- You have exhausted the Plan's internal appeal process unless you are not required to exhaust the internal appeals process under the regulations; and
- You have provided all the information and forms required to process an External Review.

Within one business day after completion of preliminary review, the Plan must issue notification in writing to you. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (call toll-free (866) 444-EBSA (3272)). If the request is not complete, such notification must describe the information and materials needed to make the request complete and the Plan 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 notification, whichever is later. Note that for an urgent care issue, the preliminary review must be done immediately and you must be notified of the decision immediately.

Referral to Independent Review Organization (IRO)
The Plan must utilize an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan must take action against bias and ensure independence.

Accordingly, the Plan must contract with at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased methods for

selection of IROs, such as random selection). The IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits. The IRO process may not impose any costs, including filing fees, on the claimant requesting the external review.

Within five business days after assignment to an IRO, the Plan must provide all documents and information considered in denying the appeal to the IRO. The IRO must provide written notice of its decision within 45 days of assignment. For urgent care issues, the IRO must provide notice of its decision as soon as possible but in no event more than 72 hours after receipt of the request for expedited external review.

Implementation of Reversal
Upon receipt of notice of final external review decision reversing an adverse benefit determination, the Plan must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits for claim).

Definitions

Air Ambulance Service means medical transport by helicopter or airplane for patients.

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 the absence of immediate medical attention to result in (i) 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, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

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

- An appropriate 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**
- Such further medical examination and treatment to stabilize the patient within the capabilities of the staff and facilities available at the hospital or the **Independent Freestanding Emergency Department**
- Further services that are furnished by an out-of-network provider or **Out-of-Network Emergency Facility** after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay (regardless of the department of the hospital in which such further examination or treatment is furnished).

Independent Freestanding Emergency Department means a health care facility that (i) is geographically separate and distinct and licensed separately from a hospital under applicable State law; and (ii) provides any **Emergency Services Network Health Care Facility** means, in the context of non-**Emergency Services**, a network hospital, hospital outpatient department, critical access hospital, or ambulatory surgical center (as defined in the Social Security Act).

Out-of-Network Emergency Facility means an emergency department of a hospital, or an **Independent Freestanding Emergency Department** (or a hospital, with respect to **Emergency**

Services as defined), that does not have a contractual relationship directly or indirectly with the Plan, with respect to the furnishing of an item or service.

Out-of-Network Rate will be determined in the following order:

- the amount that the state approves under an All-Payer Model Agreement, if applicable
- the amount determined by a state law, if applicable;
- the payment amount agreed to by the Plan and provider or facility, if applicable;
- the amount approved under the independent dispute resolution (IDR) process.

Qualifying Payment Amount (QPA) generally means the median amount the Plan has contractually agreed to pay network providers or facilities for a particular covered service. This amount is updated annually to account for inflation.

Recognized Amount, for items and services furnished by an Out-of-Network provider or **Out-of-Network Emergency Facility**, the Recognized Amount will be determined in the following order:

- An amount determined by an All-Payer Model Agreement, if applicable
- An amount determined by a specified state law, if applicable;
- The lesser of the amount billed by the provider or facility or the **Qualifying Payment Amount (QPA)**

Thank you for your participation in the Plan and please feel free to contact the Benefit Office with any questions.

Sincerely,
Board of Trustees

NOTICE: THIS IS A "GRANDFATHERED" GROUP HEALTH PLAN

This group health plan believes this coverage 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 the 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, for example, 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, for example, 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 Fund Office at (855) 251-1486.

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