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SUMMARY OF MATERIAL MODIFICATION TO THE PLUMBERS AND STEAMFITTERS LOCAL 21 WELFARE FUND

July 2022

To: **All Active, Pre-Medicare Retiree and COBRA Participants**

From: **The Board of Trustees**

Re: **Important Changes to Your Welfare Fund Medical Benefits**

The Board of Trustees of the Plumbers and Steamfitters Local 21 Welfare Fund (the "Fund") are proud of the valuable benefits provided to you and your families through the Fund. This notice describes important changes to the Plumbers and Steamfitters Local 21 Welfare Fund. Please read this notice carefully.

No Surprises Act Plan Changes

The No Surprises Act was signed into law in December 2020 and protects patients from "balance billing" for Out-of-Network Emergency Services at hospitals and certain independent freestanding emergency departments, Out-of-Network air ambulance services, and certain non-Emergency Services performed by an Out-of-Network provider at an In-Network facility (collectively, "No Surprise Services"). "Balance billing" is when an Out-of-Network provider or facility charges you for the difference between its billed amount and the Plan's Allowed (or Recognized) Amount.

Effective July 1, 2022, and subject to the rules below, Participants and their Dependents receiving No Surprises Services will only be responsible for paying their In-Network cost sharing and **cannot** be balance billed by the provider or facility for those services. **Please keep in mind that this special rule applies only to covered services that are also No Surprise Services. Other Out-of-Network services remain subject to the existing rules of the Plan.** That being the case, you are still encouraged to use In-Network (Participating) providers whenever possible.

No Surprises Act: No Surprises Services - Emergency Services

The No Surprises Act requires Emergency Services to be covered as follows:

- Without the need for any prior authorization determination, even if the services are provided on an Out-of-Network basis;
- Without regard to whether the health care provider furnishing the Emergency Services is an In-Network Provider or an In-Network emergency facility, as applicable, with respect to the services;
- Without imposing any administrative requirement or limitation on Out-of-Network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from In-Network Providers and In-Network emergency facilities;
- Without imposing cost-sharing requirements on Out-of-Network Emergency Services that are greater than the requirements that would apply if the services were provided by an In-Network Provider or In-Network emergency facility;
- By calculating the cost-sharing requirement for Out-of-Network Emergency Services as if the total amount that would have been charged for the services were equal to the Allowed (or Recognized) Amount for the services; and
- By counting cost-sharing payments you make with respect to Out-of-Network Emergency Services toward your deductible and In-Network out-of-pocket maximum in the same manner as those received from an In-Network Provider.

Please note, the Fund already does not require prior authorization for most emergency services and applies the same cost-sharing provisions to emergency services regardless of whether they are provided In-Network or Out-of-Network. A key change starting July 1, 2022 is that you will no longer be responsible for balance billing associated with the use of Out-of-Network Emergency Services. In addition, the definition of Emergency Services is being expanded (see below for the expanded definition).

No Surprises Act: No Surprises Services - Non-Emergency Services Performed by an Out-of-Network Provider in an In-Network Facility

The No Surprises Act requires non-Emergency Services performed by an Out-of-Network Provider at an In-Network Facility to be covered as follows:

- With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by an In-Network Provider;
- By calculating the cost-sharing requirements as if the total amount that would have been charged for the items and services by such In-Network Provider were equal to the Allowed (or Recognized) Amount for the items and services; and
- By counting any cost-sharing payments made toward any deductible and In-Network out-of-pocket maximums applied under the Plan in the same manner as if such cost-sharing payments were made with respect to items and services furnished by an In-Network Provider.

Notice and Consent Exception: Non-emergency items or services performed by an Out-of-Network Provider at an In-Network facility will be covered based on the Out-of-Network cost-sharing if:

- At least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), you are provided with a written notice, as required by federal law, that the provider is an Out-of-Network provider with respect to the Plan, the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, the names of any In-Network providers at the facility who are able to treat you, and that you may elect to be referred to one of the In-Network providers listed; and

- You give informed consent to continued treatment by the Out-of-Network provider, acknowledging that you understand that continued treatment by the Out-of-Network provider may result in greater cost to you.

The Notice and Consent Exception does not apply to Ancillary Services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Out-of-Network provider satisfied the Notice and Consent Exception criteria.

No Surprises Act: Out-of-Network Air Ambulance Services

If you receive Air Ambulance services that are otherwise covered by the Plan from an Out-of-Network provider, those services will be covered by the Plan as follows:

- The Air Ambulance services received from an Out-of-Network provider will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the services had been furnished by an In-Network provider.

- In general, you cannot be balance billed for these items or services. Your cost-sharing will be calculated as if the total amount that would have been charged for the services by an In-Network provider of Air Ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services.

- Any cost-sharing payments you make with respect to covered Air Ambulance services will count toward your In-Network deductible and In-Network out-of-pocket maximum in the same manner as those received from an In-Network provider.

No Surprises Act: Continuity of Coverage

If you are a Continuing Care Patient (see New Definitions section below), and Empire terminates its In-Network contract with an In-Network provider or facility (except in the case of a termination of the contract for failure to meet applicable quality standards or for fraud), or your benefits are terminated because of a change in terms of the providers' and/or facilities' participation in the network:

- You will be notified in a timely manner of the contract termination and of your right to elect continued transitional care from the provider or facility; and

- You will be allowed up to ninety (90) days of continued coverage at In-Network cost sharing to allow for a transition of care to an In-Network provider or facility (provided you otherwise remain eligible under the Plan).

No Surprises Act: Incorrect In-Network Provider Information

A list of In-Network providers is available to you without charge by visiting www.empireblue.com or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, who are contracted with the Plan or an organization contracting on its behalf.

Empire updates its directories every ninety (90) days and will respond to your inquiry about the network status of a provider or facility within one business day.

If you obtain and rely upon incorrect information about whether a provider is an In-Network provider from the Plan or Empire, the Plan will apply In-Network cost-sharing to your claim, even if the provider was an Out-of-Network provider at the time the service was rendered. Please remember, however, that it is your responsibility to confirm that the Provider or facility that you have selected is In-Network at the time you receive services.

No Surprises Act: Complaint Process

If you believe you've been wrongly billed, or otherwise have a complaint under the No Surprises Act or the Health Plan Transparency Rule, you may contact the Fund Office or the Employee Benefit Security Administration (EBSA) toll free number at 1-866-444-3272.

No Surprises Act: External Review Process of Certain Coverage Determinations

If your claim for benefits related to a No Surprises Service has been denied (i.e., an adverse benefit determination), and you are dissatisfied with the outcome after exhausting the Plan's internal claims and appeals process, you may be eligible for External Review of the determination if your appeal relates to whether the Plan is complying with the No Surprises Act. Please contact the Fund Office for a copy of the Fund's External Review procedures.

No Surprises Act: New Definitions of Key Terms

To implement the protections of the No Surprises Act, the Fund is adopting the following new/revised definitions of key terms in the Plan.

"Ancillary Services" means, with respect to a participating Health Care Facility, the following:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services; and
- Items and services provided by a Out-of-Network provider if there is no In-Network provider who can furnish such item or service at such facility.

"Continuing Care Patient" means an individual who is: (1) receiving a course of treatment for a Serious and Complex Condition (defined below); (2) scheduled to undergo non-elective surgery (including any post-operative care); (3) pregnant and undergoing a course of treatment for the pregnancy; (4) determined to be terminally ill and receiving treatment for the illness; or (5) is undergoing a course of institutional or inpatient care from the provider or facility.

“Emergency Medical Condition” means a medical condition, including mental health condition or substance use disorder, manifested 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

- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part; or
- Placing the health of a woman or her unborn child in serious jeopardy.

“Emergency Services” means the following:

- An appropriate medical screening examination that is within the capability of the emergency department of a hospital 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 or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).
- Emergency services furnished by an Out-of-Network provider or Out-of-Network emergency facility (regardless of the department of the hospital in which such items or services are furnished) after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay related to the Emergency Medical Condition, until:
    - The provider or facility determines that you are able to travel using non-medical transportation or non-emergency medical transportation; and
    - You are supplied with a written notice, as required by federal law, that the provider is an Out-of-Network Provider with respect to the Health Fund, of the estimated charges for your treatment and any advance limitations that the Health Fund may put on your treatment, of the names of any In-Network Providers at the facility who are able to treat you, and that you may elect to be referred to one of the In-Network Providers listed; and
    - You give informed consent to continued treatment by the Out-of-Network Provider, acknowledging that you understand that continued treatment by the Out-of-Network Provider may result in greater cost to you.

“Health Care Facility” (for non-Emergency Services) means each of following:

- A hospital (as defined in section 1861(e) of the Social Security Act);
- A hospital outpatient department;
- A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and
- An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act

“No Surprises Services” means the following, to the extent covered under the Plan:

- Out-of-Network Emergency Services;
- Out-of-Network air ambulance services;
- Non-emergency ancillary services for anesthesiology, pathology, radiology and diagnostics, when performed by an Out-of-Network Provider at an In-Network facility; and
- Other out-of-network non-Emergency Services performed by an Out-of-Network provider at an In-Network Health Care Facility with respect to which the provider does not comply with federal notice and consent requirements.

“Allowed Amount” or **“Recognized Amount”** means the maximum amount the Plan will pay for the services or supplies covered under this Plan, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. Empire determines the Allowed (or Recognized) Amount as follows:

- The Allowed Amount for Participating Providers will be the amount Empire has negotiated with the Participating Provider, or the amount approved by another Host Plan, or the Participating Provider’s charge, if less.
- The Allowed Amount for Non-Participating Providers will be determined as follows:
  - For Facilities, the Allowed (or Recognized) Amount will be the average amounts paid by Empire for comparable services to Empire’s Participating Hospitals/Facilities in the same county. If there are no like kind Participating Hospitals and/or Facilities in the same county, then the average of amounts paid by Empire for comparable services in like kind Participating Hospitals and/or Facilities in the contiguous county or counties.
  - For all other Providers, the Allowed (or Recognized) Amount is 150% of the Centers for Medicare and Medicaid Services Provider fee schedule, as applicable to the Provider type, unadjusted for geographic locality.
- The Allowed (or Recognized) Amount for No Surprises Services, also referred to as the Recognized Amount, is determined as follows:
  - An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
  - An amount determined by a specified state law (if applicable); or
  - The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (“QPA”)

  For air ambulance services furnished by Out-of-Network providers, the Allowed (or Recognized) Amount is the lesser of the amount billed by the provider or facility or the QPA.

“Qualifying Payment Amount” or “QPA” means generally the median contracted rates of the Plan for the item or service in the geographic region, calculated in accordance with 29 CFR § 716-6(c).

“Serious and Complex Condition” means one of the following:

- 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
- In the case of a chronic illness or condition, a condition that is the following:
  - Life-threatening, degenerative, potentially disabling, or congenital; and
  - Requires specialized medical care over a prolonged period of time.

Other Plan Changes and Clarifications

Health Reimbursement Arrangement ("HRA")

Effective July 1, 2021, "Eligible Medical Expenses" means expenses incurred for medical care, as defined in Internal Revenue Codes §105 and §213(d). This means that if a medical expense was previously excluded from coverage under the HRA due to a Plan exclusion but is otherwise an Eligible Medical Expense under the Internal Revenue Code, it is now considered to be an Eligible Medical Expense under the HRA.

These expenses are explained in detail under IRS Publication 502, which is updated annually by the IRS.

Please note that this change substantially modifies the types of medical expenses covered under the HRA. The Fund Office is currently working to provide a fully restated HRA section of the Summary Plan Description to replace the current section. If you have a question about whether an expense is reimbursable through the HRA, please call the Fund Office.

Digital Therapy Exclusion

Effective March 1, 2021, the Fund does not cover digital therapy. As such, the following exclusion is added to the Exclusions and Limitations sections of the Medical Benefits and Prescription Drug Benefits sections of the Summary Plan Description.

> **Digital Therapy.** Any and all charges for, or related to, Digital Therapy treatments, whether those therapies have received approval from the U.S. Food and Drug Administration (FDA) or not, or are considered experimental or investigational.

Additionally, a new key term definition defining Digital Therapy is added as follows:

> **"Digital Therapy"** means a non-medication treatment that uses digital technology (usually internet-based) to drive patients to change their behavior in order to prevent, manage, or treat a medical disorder or disease.

Extension of Coverage for Disability

Effective January 1, 2021, if, after you've met the initial eligibility requirements, you do not meet the work hours required to maintain eligibility due to being or having been on short-term disability or worker's compensation for a period of 12 weeks in the prior one-year period, you may self-pay for up to 500 hours to maintain eligibility for one calendar quarter. This extension of coverage for disability may not be applied in

consecutive calendar quarters. Once you are no longer eligible for coverage, you will be offered COBRA Continuation of Coverage.

Plan Sponsor: Plumbers and Steamfitters Local 21 Welfare Fund
Sponsor's EIN: 13-4017983
Plan Number: 501
Plan Year: July 1st to June 30th

You should keep this Notice together with your Summary Plan Description at all times. The two documents should be read together for an accurate depiction of your current health plan benefits. If you have any questions, contact the Fund Office.

The Board of Trustees or its duly authorized designee, reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan, or any benefits provided under the Plan, in whole or in part, at any time and for any reason, in accordance with the applicable amendment procedures established under the Plan and the Agreement and Declaration of Trust establishing the Plan (the "Trust Agreement").

No individual other than the Board of Trustees (or its duly authorized designee) has any authority to interpret the plan documents, make any promises to you about benefits under the Plan, or to change any provision of the Plan. Only the Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the terms of the Plan and decide all matters arising under the Plan.