OE3 Trust Funds
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March 2022

TO: All Participants and their Dependents, including COBRA beneficiaries, of the Operating Engineers Health and Welfare Trust Fund

FROM: Board of Trustees
Operating Engineers Health and Welfare Trust Fund

The information described in this document is **important**. Please read it carefully.

SUMMARY OF MATERIAL MODIFICATIONS TO THE COMPREHENSIVE MEDICAL BENEFITS PLAN:

Effective January 1, 2022

This Summary of Material Modifications advises you of changes in the information contained in the Operating Engineers Health and Welfare Trust Fund Summary Plan Description (SPD), as required by the Employee Retirement Income Security Act of 1974. The Trustees of the Operating Engineers Health and Welfare Trust Fund for Operating Engineers (the "Fund") have amended the Plan Document and Summary Plan Description to comply with the No Surprises Act.

The No Surprises Act (NSA) was signed into law in December 2020, as part of the Consolidated Appropriations Act, 2021. The NSA protects Patients who experience Emergency Services, certain non-emergency services performed by a Non-Contract Provider at a Contract (i.e., in-network) Health Care Facility (unless the Patient gives informed consent), and Air Ambulance Services by a Non-Contract Provider (collectively, "No Surprises Services"). As described below, Employees and their Dependents receiving No Surprises Services will only be responsible for paying their in-network cost-sharing requirement and, in general, may not be balance billed. Further, as a result of the NSA, we have amended and/or added definitions and terms to the Plan Document and made improvements to your benefits when using a Non-Contract Provider for certain services. Capitalized terms are defined further below or in the Plan Document.

You are encouraged to use Contract Providers and Contract Facilities when possible. Please review the following changes carefully and contact the Fund Office with any questions that you may have.

NO SURPRISES ACT: EMERGENCY SERVICES, SERVICES PROVIDED BY NON-CONTRACT PROVIDERS IN CONTRACT FACILITIES, AND AIR AMBULANCE SERVICES

Effective on or after January 1, 2022

1. Emergency Services

   The Fund will cover Emergency Services without the need for any prior authorization determination, even if the services are provided at a Non-Contract Facility, such as an out-of-network Hospital emergency department or an Independent Freestanding Emergency

Department, and without regard to whether the health care provider furnishing the Emergency Services is a Contract Provider or a Contract Facility. Furthermore, the Fund will not impose any administrative requirements or limitations on Emergency Services received from a Non-Contract Provider or Facility that are more restrictive than the requirements or limitations that apply to Emergency Services received from a Contract Provider or Facility.

The cost-sharing for Emergency Services performed by a Non-Contract Provider or Facility will be the same as the cost sharing for Emergency Services performed by a Contract Provider or Facility and will be based on the Recognized Amount payable for these services. Your cost sharing payments for Emergency Services performed by a Non-Contract provider or facility count toward your deductible and out-of-pocket maximum as if the services were received from a Contract Provider.

In general, you cannot be balance billed for Emergency Services.

2. Non-Emergency Services Provided by Non-Contract Providers at a Contract Facility

Your cost-sharing for non-emergency services by a Non-Contract-Provider at a Contract Facility will be no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a Contract Provider.

The Fund will calculate the cost-sharing requirements as if the items and services were provided by a Contract Provider and calculated at the Recognized Amount for those items and services.

Your cost sharing payments for Non-Emergency Services performed by a Non-Contract Provider at a Contract Health Care Facility will be counted toward your Contract Provider deductible and Contract Provider out-of-pocket maximum.

In general, you cannot be balance billed for these items or services.

Notice and Consent Exception

Non-emergency items or services performed by a Non-Contract Provider at a Contract Facility will be covered based on the Plan's definition of Allowed Charge and forgo the financial protections of the No Surprises Act 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 a Non-Contract 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 Contract Providers at the facility who are able to treat you, and that you may elect to be referred to one of the Contract Providers listed; and
- You give written informed consent to continued treatment by the Non-Contract Provider, acknowledging that you understand that continued treatment by the Non-Contract 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 Non-Contract Provider satisfied the notice and consent criteria.

3. Air Ambulance Services

   Air Ambulance Services are medical transport for Patients by a rotary wing air ambulance, as defined in 42 CFR § 414.605, or fixed wing air ambulance, as defined in 42 CFR § 414.605. Your cost sharing for Air Ambulance Services from a Non-Contract 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 a Contract Provider.

   The Fund will calculate your cost sharing amount as if the total amount that would have been charged for the services by a Contract Provider of Air Ambulance Services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services

   Your cost sharing payments for Air Ambulance Services performed by a Non-Contract Provider will be counted toward your in-network deductible and out-of-pocket maximum.

   In general, you cannot be balance billed for Air Ambulance Services.

4. Continuing Care Patient

   If you are a Continuing Care Patient and the Plan terminates its PPO contract with a Contract Provider or Contact Facility or Hospital, or your benefits are terminated because of a change in terms of the Providers' and/or Facilities' participation in the Plan, the Plan will do the following:

   a) Notify you in a timely manner of the Plan's termination of its contracts with the Contract Provider or Facility and inform you or your representative of your right to elect continued transitional care from the provider or facility; and

      Allow you ninety (90) days of continued coverage at the in-network sharing to allow for a transition of care to a Contract Provider or Facility.

5. Provider Directory

   The Provider Directory will be updated at least every ninety (90) days. If you are informed by the Plan through a telephone, electronic, or internet-based inquiry, or receives information from a current print or electronic Provider Directory that a provider is a Contract Provider, but, in fact, the provider is a Non-Contract Provider and services are furnished by that Non-Contract Provider, the Plan will:

   a) Apply a cost-sharing amount that is no greater than the cost-sharing amount that would have been assessed if the provider was a Contract Provider; and

   b) Apply the out-of-pocket limit, if any, as if the services were provided by a Contract Provider.

6. Your Cost Sharing.

   In accordance with the No Surprises Act, your cost-sharing for No Surprise Services will be based on the Recognized Amount, which will generally be the lesser of the billed charges from the Non-Contract Provider or the Qualifying Payment Amount.

EXTERNAL REVIEW OF CLAIMS

Effective January 1, 2022

If an appeal of a health care claim, whether urgent, concurrent, pre-service, or post-service, is denied, you may request external review by an independent review organization (IRO) if the denial involves any of the following:

a) The denial involves medical judgment, including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational. The IRO will determine whether a denial involves a medical judgment;

b) The denial is due to a Rescission of coverage (i.e., any cancellation or discontinuance of coverage that has a retroactive effect), regardless of whether the rescission has any effect on any particular benefit at that time; and

c) The denial involves surprise billing or cost-sharing issues that are protected under the No Surprises Act for Emergency Services, Air Ambulance Services, and non-emergency services provided by a Non-Contract Provider at a Contract Facility.

NEW/REVISED DEFINITIONS OF THE PLAN

Effective January 1, 2022

To implement the protections of the No Surprises Act, the Fund is adopting the following new/revised definitions of terms in the Plan effective January 1, 2022.

1. **Allowed Charge**. The term "Allowed Charge" means the lesser of:

   a) For Emergency Services provided by Non-Contract Providers, for Non-Emergency Services provided by a Non-Contract Provider at a Contract Facility, and for Air Ambulance Services, the Out-of-Network Rate**.**

   b) For all other services, the lesser of:

      (1) The dollar amount this Plan has determined it will allow for covered Medically Necessary services or supplies provided by Non-Contract Providers as determined by the Plan's Preferred Provider Organization based on appropriate and reasonable charges for the services in the geographical area where the services are provided. The Plan's Allowed Charge is not based on or intended to be reflective of fees that have traditionally been described as usual and customary (U&C), usual, customary and reasonable (UCR), or any other traditional term. Non-Contract Providers' bills often exceed the Plan's Allowed Charge, and in such cases the Plan's benefits will be based on the Allowed Charge not the Non-Contract Provider's billed rate. When a Patient has not had a reasonable opportunity to select a Contract Provider, the Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review organization to assist the Plan in determining the Allowed Charge for the submitted claim. This review by an independent medical review firm is separate and

apart from any independent dispute resolution process that is facilitated pursuant to the No Surprises Act.

(2) The Non-Contract Provider's actual billed charge.

c) When using Non-Contract Providers, except for No Surprises Act Services, the Eligible Individual is responsible for any difference between the actual billed charge and the Plan's Allowed Charge (a practice called "balance billing"), in addition to any copayment and percentage coinsurance required by the Plan.

2. **Ancillary Services** means, with respect to a participating health care facility, the following:

   a) Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;

   b) Items and services provided by assistant surgeons, hospitalists, and intensivists;

   c) Diagnostic services, including radiology and laboratory services; and

   d) Items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.

3. **Continuing Care Patient** means an individual who is:

   - undergoing a course of treatment for a Serious and Complex Condition from the provider or facility;
   - undergoing a course of institutional or inpatient care from the provider or facility;
   - scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
   - pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
   - determined to be terminally ill and receiving treatment for such illness from such provider or facility.

4. **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; serious dysfunction of any bodily organ or part; or 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.

   The Fund Office or its designee has the discretion and authority to determine if a treatment, service, or supply is or should be classified as treatment of an Emergency Medical Condition.

5. **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 a Non-Contract provider or Non-Contract emergency facility (regardless of the department of the hospital in which such items or services are furnished also includes post stabilization services (services 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 nonmedical transportation or nonemergency medical transportation; and
  - You are supplied with a written notice, as required by federal law, that the provider is a Non-Contract Provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any Non-Contract Providers at the facility who are able to treat you, and that you may elect to be referred to one of the Contract Providers listed; and
  - You give written informed consent to continued treatment by the Non-Contract Provider, acknowledging that you understand that continued treatment by the Non-Contract Provider may result in greater cost to you.

6. **Health Care Facility** (for non-emergency services) means each of following:
   a) A hospital (as defined in section 1861(e) of the Social Security Act);
   b) A hospital outpatient department;
   c) A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and
   d) An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act
7. **Independent Freestanding Emergency Department** means a health-care facility (not limited to those described in the definition of health care facility) that is geographically separate and distinct from a hospital under applicable state law and provides Emergency Services
8. **No Surprises Act Services** means the following, to the extent covered under the Plan: (1) out-of-network Emergency Services, (2) out-of-network Air Ambulance Services; (3) non-emergency Ancillary Services for anesthesiology, pathology, radiology and diagnostics, when performed by a Non-Contract Provider at a Contract Facility; and (4) other out-of-network non-emergency services performed by Non-Contract Provider at a Contract Health Care Facility with respect to which the provider does not comply with written federal notice and consent requirements.

   Out of Network Rate. With respect to 1) Emergency Services provided by a Non-Contract Hospital or Independent Freestanding Emergency Department, 2) non-emergency services furnished by a Non-Contract Provider at a Contract Facility, and 3) Air Ambulance Services by a Non-Contract Provider, the term "Out-of-Network Rate" means one of the following in the order of priority:

- If the state has an All-Payer Model Agreement, the amount that the state approves under that system;
- Applicable state law;
- The amount parties negotiate; or
- The amount approved under the independent dispute resolution (IDR) process pursuant to the No Surprises Act when open negotiations fail.

9. **Qualifying Payment Amount** means, generally, the median contracted rates of the plan or issuer for the item or service in the geographic region, calculated in accordance with 29 CFR § 716-6(c).
10. **Recognized Amount** means (in order of priority) one of the following:
    a) An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
    b) An amount determined by a specified state law; or
    c) The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA)

    For Air Ambulance Services furnished by Non-Contract providers, the Recognized Amount is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.
11. **Serious and Complex Condition** means one of the following:
    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 the following:
       - Life-threatening, degenerative, potentially disabling, or congenital; and
       - Requires specialized medical care over a prolonged period of time.

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Receipt of this notice does not constitute a determination of your eligibility. If you wish to verify eligibility, or if you have any questions regarding this Plan change, please contact the Fund Office.

If you have any questions, please contact the Trust Fund Office at the numbers listed above. You may also call the Fringe Benefits office at (800) 532-2105.

Sincerely,

Board of Trustees

Operating Engineers Health and Welfare Trust Fund

- If you purchased a self-test for COVID-19 that has been authorized for emergency use by the FDA and need to submit a medical claim for reimbursement, go to kp.org for directions on how to submit your claim.
- To be reimbursed, the claim submitted must include:
  - An itemized purchase receipt with the test name, the date of purchase, the price, and number of tests
  - A photo of the QR or UPC code cut out from the self-test box if submitting online. If you are submitting a paper claim by mail, mail in the cut out QR or UPC code and not the entire package.
- By submitting a claim for reimbursement, you are attesting that the self-test was purchased for personal use, is not for employment purposes unless required by applicable state law, has not and will not be reimbursed by another source, and is not for resale.

If you have any questions, please contact the Trust Fund Office at the numbers listed above. You may also call the Fringe Benefits office at (800) 532-2105.

Sincerely,
Board of Trustees

Receipt of this notice does not constitute a determination of your eligibility. If you have any questions regarding the Plan changes, please contact the Trust Fund Office.

In accordance with ERISA reporting requirements, this document serves as your Summary of Material Modifications to the Plan and we are advising you of these Plan changes within 60 days of the adoption of those changes.