SUMMARY OF MATERIAL MODIFICATIONS TO
THE HEALTH AND BENEFIT TRUST FUND OF THE INTERNATIONAL UNION OF OPERATING ENGINEERS
LOCAL 94-94A-94B, AFL-CIO

Commercial and School Division

To: **All Commercial and School Division Participants in the Health and Benefit Trust Fund of the International Union of Operating Engineers Local 94-94A-94B, AFL-CIO**

From: **The Plan Administrator of the Health and Benefit Trust Fund of the International Union Operating Engineers Local 94-94A-94B, AFL-CIO – Commercial and School Division**

Re: **Changes Required under the No Surprises Act**

Date: **April 28, 2022**

This document is a Summary of Material Modifications ("SMM") intended to notify you of important changes under the Health and Benefit Trust Fund of the International Union of Operating Engineers Local 94-94A-94B, AFL-CIO's (the "Fund's") Plan of benefits (the "Plan"). This summary is intended to satisfy the requirements for issuance of a SMM under the Employee Retirement Income Security Act of 1974, as amended. You should take the time to read this SMM carefully and keep it with the Summary Plan Description ("SPD") that was previously provided to you. If you need another copy of the SPD or if you have any questions regarding these important changes, please contact the Plan Administrator during normal business hours at: 331-337 West 44th Street, New York, New York, 10036, telephone number: (212) 331-1800.

Beginning January 1, 2022, the Fund is implementing changes to the Plan as required by the No Surprises Act, which is a new federal law that protects healthcare consumers from receiving surprise bills from Out-of-Network Providers in certain situations. This Summary of Material Modifications describes these changes, which are effective January 1, 2022.

In-Network Cost-Sharing/No Balance Billing for Covered Services subject to the No Surprises Act

Typically, under the Plan, if you receive medical services from an Out-of-Network Provider, you are responsible for Out-of-Network Cost-Sharing amounts (including any Copayments, Coinsurance and Deductible) plus the amount, if any, by which the Out-of-Network Provider's actual charge exceeds the Plan's Allowed Amount for the Covered Services.

However, beginning January 1, 2022, if you received Out-of-Network Covered Services that are also subject to the No Surprises Act, your Cost-Sharing will be the same as if you had received those services from an In-Network Provider.

This means that you will **not** have to satisfy the Out-of-Network Deductible, Copayment or Coinsurance for these services, and you will **not** have to pay the amount billed by the Out-of-Network Provider that exceeds the Plan's normal Allowed Amount for the Covered Service. Instead, you will only pay the In-Network Cost-Sharing, which generally is the In-Network Deductible, Copayment and/or Coinsurance. (In the very limited cases in which there is In-Network Coinsurance, your Coinsurance is based on a percentage of the amount required by the No Surprises Act, which will usually be the qualifying payment amount. The qualifying payment amount is generally the median contracted rate for the item or service in the same geographic region, as adjusted under Department of Labor Regulations.)

In addition, if you receive Out-of-Network Covered Services subject to the No Surprises Act, the Plan pays the Out-of-Network Provider directly, based on the terms of the No Surprises Act. In that case, the Out-of-Network Provider is generally prohibited from sending you a "balance bill" for charges billed for otherwise Covered Services in excess of the amount on which the Plan based its payment.

Covered Services under the No Surprises Act

The following services are Covered Services that are subject to the No Surprises Act:

- Emergency Services at an Out-of-Network health care facility or provided by an Out-of-Network Provider (unless you consent to be treated by the Out-of-Network Provider for certain post-stabilization services – see below)

- Non-emergency services provided by an Out-of-Network Provider at an In-Network health care facility (unless you consent to be treated by the Out-of-Network Provider, if applicable – see below)

- Out-of-Network air ambulance services

Please keep in mind that the special rules described above only apply to Covered Services subject to the No Surprises Act. Other Out-of-Network Covered Services remain subject to the normal rules of the Plan.

Please also note that regardless of whether a Covered Service is also subject to the No Surprises Act, you are always responsible for any expenses or charges billed by any provider or facility that are not medically necessary or are otherwise not Covered Services under the Plan.

Definition of Emergency Services

The Plan covers Emergency Services for the treatment of an Emergency condition. Effective January 1, 2022, the special rules for the No Surprises Act apply as described above, and Emergency Services and Emergency condition are defined in the Plan as follows:

Emergency 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 serious medical complications, loss of life, serious impairment of bodily functions, or serious dysfunction of a body part.

Emergency Services means, with respect to an Emergency condition:

- An appropriate medical screening examination that is within the capability of an emergency room of a hospital or independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency condition; and

- Such further medical examination and treatment as are required to stabilize the patient within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable (regardless of the department of the hospital in which such further examination or treatment is furnished); and
- Post-stabilization services, which are services furnished by Out-of-Network Providers or Out-of-Network facilities after the patient is stabilized as part of outpatient observation or an inpatient/outpatient stay related to the Emergency condition (regardless of the department of the hospital in which such further

examination or treatment is furnished), until: (1) the treating provider or facility determines that the individual is able to travel using non-medical transportation or non-emergency medical transportation; and (2) the individual is provided with appropriate written notice to consent to Out-of-Network treatment (see below) and gives informed consent to such Out-of-Network treatment.

Ground ambulance services are not Emergency Services for the purposes of the No Surprises Act and will be covered under the normal terms set forth in the SPD.

Please remember that if you go to the emergency room for medical services or treatment for a condition that is not an Emergency condition, as defined above, it may not be covered by the Plan. See the SPD for more information.

Consent Requirements

The special rules for Covered Services subject to the No Surprises Act will not apply in certain circumstances if you consent to receiving treatment from an Out-of-Network Provider. These consent rules apply to (i) non-emergency services provided at an In-Network facility other than ancillary services (described below) or (ii) Emergency Services that are post-stabilization services. If you do consent, as with other Out-of-Network services, you will be responsible for Out-of-Network Cost-Sharing amounts (including any Copayments, Coinsurance and Deductible) plus the amount, if any, by which the Out-of-Network Provider's actual charge exceeds the Plan's Allowed Amount for the Covered Services.

In order for the consent to be valid, certain regulatory requirements must be satisfied, including the following:

- You are provided with written notice: (1) that the provider is an Out-of-Network Provider; (2) of any estimated charges for treatment; (3) of any applicable advance limitations under the Plan; (4) that consent to receive treatment by such Out-of-Network Provider is voluntary; and (5) that you may instead seek care from an In-Network Provider. In the case of non-Emergency Services this notice must be provided at least 72 hours before the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), and on the day of the appointment.

- You give signed, informed consent (consistent with regulatory requirements) to treatment by the Out-of-Network Provider, acknowledging that you understand that treatment by the Out-of-Network Provider may result in greater out-of-pocket costs compared to treatment by an In-Network Provider.

For non-emergency services, the "notice and consent" exception above does not apply to ancillary services or to items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished. For this purpose, ancillary services include (i) items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology (whether provided by a physician or non-physician practitioner); (ii) items and services provided by assistant surgeons, hospitalists, and intensivists; (iii) diagnostic services, including radiology and laboratory services; and (iv) items and services provided by an Out-of-Network Provider if there is no In-Network Provider who can furnish such items or services at the facility.

Claim Determinations for Claims Subject to Surprise Billing Protections

The claims administrator will make an initial payment or notice of denial of payment for Emergency Services at Out-of-Network health care facilities, non-emergency services provided by Out-of-Network Providers at In-Network facilities, and/or Out-of-Network air ambulance services within (30) calendar days of receiving a claim from the Out-of-Network Provider or facility that includes all necessary information to decide the claim.

Continuity of Coverage

Beginning January 1, 2022, the Plan will provide "continuity of coverage" in certain situations where a termination of a contractual arrangement changes the In-Network status of a provider or facility to Out-of-Network (except in the case of a termination of the contract for failure to meet applicable quality standards or for fraud).

Specifically, if you are a "Continuing Care Patient," you will be notified of the contract termination and your right to elect continued transitional care from the provider or facility; and, you will be allowed ninety (90) days of transitional care from the provider or facility at In-Network Cost-Sharing to allow you time to transition to a new In-Network Provider or facility (provided you remain eligible for Plan coverage).

A Continuing Care Patient is an individual, who, with respect to a provider or facility, (i) is undergoing a course of treatment for an acute illness (serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm) or chronic illness or condition (life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time); (2) is undergoing a course of institutional or inpatient care from the provider or facility; (3) is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility; (4) is pregnant or undergoing a course of treatment for the pregnancy from the provider or facility; or, (5) is or was determined to be terminally ill (under SSA § 1862(dd)(3)(A)) and is receiving treatment for such illness from such provider or facility.

Provider Directory Updates

To help you find care from In-Network Providers and facilities, Empire maintains a provider directory. Empire updates its provider directory 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 receive inaccurate information from Empire or the Fund office about a provider or facility's network status, you will be liable only for In-Network cost sharing for the services underlying your inquiry. However, it is your responsibility to confirm that the provider or facility that you have selected is In-Network at the time you receive services.

To find an In-Network Provider, call the Fund Office at (212) 331-1800 or Empire at 1-833-604-1470 or view the network's provider listings at www.empireblue.com.

Please feel free to reach out to the Fund Office if you have any questions or need additional information.

Sincerely,

Board of Trustees, Health and Benefit Trust Fund of the International Union of Operating Engineers Local 94-94A-94B, AFL-CIO

This SMM is intended to provide you with an easy-to-understand description of material changes concerning the Plan. While every effort has been made to make this description as complete and as accurate as possible, this SMM, of course, cannot contain a full restatement of the terms and provisions of the Plan. 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"). The Trust Agreement is available at the Fund Office and may be inspected by you free of charge during normal business hours. 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.

IMPORTANT NOTICE REGARDING THE PLAN'S GRANDFATHERED PLAN STATUS

The Trustees believe that the Plan is a "grandfathered plan" as such term is defined under PPACA (more commonly known as Health Care Reform). As permitted by Health Care Reform, a grandfathered health plan can preserve certain basic health coverage that was already in effect when Health Care Reform was enacted. Being a grandfathered health plan means that the medical coverage that you have elected under the plan may not include certain consumer protections of Health Care Reform that apply to other group health plans, for example, the requirement for the provision of preventive health services without any cost sharing (i.e., copayments, coinsurance, deductibles). However, grandfathered health plans must comply with certain other consumer protections in Health Care Reform, for example, the elimination of lifetime limits on benefits and extension of coverage to dependents until age 26. 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 Plan Administrator during normal business hours at: 331-337 West 44th Street, New York, New York, 10036, telephone number: (212) 331-1800. You may also contact the Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered plans.